CASE HISTORIES IN

ABNORMAL PSYCHOLOGY

Assembled by

CALVIN P. STONE

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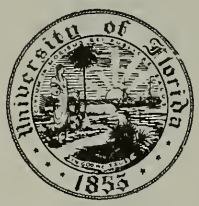

CASE HISTORIES IN ABNORMAL PSYCHOLOGY

Assembled by

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PREFACE

This assemblage of case histories grew out of the author's desire to supply his classes in army psychology with a greater variety of abnormal reaction types than was provided by their introductory textbook. The cases are used to illustrate and objectify assigned chapters in a standard textbook of abnormal psychology. Limited study-time of the student cadets made it unfeasible for them to read them in their original settings of exposition and discussion.

Because of limited space we were unable to include any of the longer epitomies. That is regrettable. As a rule, they are more illuminating than the short, relatively incomplete cases. Also, for reasons which need not be considered here, there is some unevenness in coverage of the fundamental reaction types. Some of these disadvantages can and should be offset by the instructor's presenting supplementary cases in lecture or recitation periods.

To others who may use this case book, it may be added that the instructor should be well acquainted with all of the source books from which the cases are taken in order that he may supply, as needed, each author's point of view as expressed in the original text.

The author wishes especially to acknowledge his gratitude to the publishers who own copyrights on the text materials herein reproduced for the privilege of quotation. At appropriate places in the book, specific acknowledgments will be made. Authors and titles appear in the bibliography at the end.

Calvin P. Stone

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I. MINOR MALADJUSTMENTS AND PSYCHONEUROTIC REACTION TYPES

CASE 1. Mental conflict, without neurosis. McDougall (1), p. 218.*

A young man, preparing for the ministry, had been for some years a member of a lay brotherhood. He had continued as a lay brother because he felt that he was not yet ready for the graver responsibility; a fact which indicates his high degree of conscientiousness. Soon after the outbreak of the war he volunteered for service, though he was very far from Europe, and joined the Medical Corps. He was soon sent to the front as a stretcher-bearer. There he found that the explosion of shells provoked in him uncontrollable fear; every time a shell exploded near him, he was moved by an uncontrollable impulse to dash for cover. He was much distressed by his liability to fear and his inability to control its impulse; he struggled hard to get the better of his weakness, hoping that he would be more successful as he disciplined himself and that, on repetition of these experiences, familiarity would weaken the force of the impulse. But no improvement came. He had been taught to believe, and he did believe, that, if he prayed earnestly for strength, strength would be given him. And so he prayed earnestly and often for such increase of strength. It was, or seemed to him, a crucial test of his religious beliefs. He was asking for no miraculous intervention in the physical order of things; he was praying for strength to enable him to do his duty, to succour comrades stricken in what he believed to be a noble and righteous cause. He felt that his prayers were wholly reasonable, that his motives and his aim were wholly good. Surely, God would help him! But there was no answer to his prayer; no strength came. Rather he went from bad to worse. He felt that his religious belief was crumbling away; and his distress was accentuated. He could sleep but little; and he became emaciated and increasingly "jumpy" and less able to do his duty; until at last a merciful officer sent him to hospital. There he found little relief; for, though he no longer suffered the frequent shocks of fear, the inner conflict continued. He still desired strongly to do his duty as a soldier; but he had no hope of overcoming his shameful fear impulse. Thousands of men in similar situations were breaking down with all sorts of neurotic disabilities, paralyses and amnesias, and so forth. His conflict found no such partial solution and relief; for his training had accustomed him to search his own heart, to understand and frankly examine his motives; therefore the conflict took place in the open, on the plane of full consciousness. He had no positive symptoms of functional disorder; he wandered restlessly about the hospital seeking to make himself useful, his emaciated face bearing an expression of intense distress, his mind the seat of an unceasing conscious conflict. On almost every occasion that I came near him, he would draw me aside and beg earnestly to be sent back to the front. He was the victim of a conflict of which there could be no solution so long as the war continued; there could be no peace of mind for him, unless he should be fortunate enough to receive a severe or fatal wound. I have no doubt of his entire sincerity, when he expressed the desire to find death on the battlefield.†

*This and cases 17, 26, 29, 30, and 31 reprinted by permission from Outline of Abnormal Psychology by Wm. McDougall, published by Chas. Scribner's Sons.

†It is a common fallacy, countenanced even by some great psychologists, that fear is essentially the fear of death. A moment's reflection on the comparative facts should suffice to dispel the error. Animals show all the signs of fear, though they have no conception of death; and the same is true of young children. Many a man who does not fear death is subject to fear upon occasion. And many a man who could face death boldly in spite of fear, is yet subject to uncontrollable fear, fear provoked by objects or situations which he knows to be harmless, carrying no threat of death or injury.

CASE 2. Temporary maladjustment in an officer. Layman (2), p. 156.*

Complaint. The patient was a 22-year-old second lieutenant, who experienced difficulties in adjusting both to his duties and in his interpersonal relationships. The problem, as stated by the patient, centered chiefly in not being allowed sufficient nights off his post when not officially on duty. Also, there were some complaints that his immediately superior officer, with whom he also shared quarters, was "unfriendly." This, according to the patient, was evidenced by "jibes" at patient's reading interests and rebuffing his offer to share such personal possessions as a radio. These difficulties resulted in complaints of "nervousness" and disturbances of his gastro-intestinal tract.

Reports from the patient's superior officers elicited the following (abstracted): (1) Good ability in performance of duties, provided they were outlined to him in detail, but assignments inadequately carried out when patient was left to his own devices; (2) complaints to his commanding officer that he was unfairly discriminated against when limited to three nights weekly off post (because of a post ruling to this effect as well as the patient's own need for further study of military material pertaining to his assignment); (3) resorting to crying when so restricted and stating that he "never had an opportunity to enjoy himself" prior to coming on to duty; (4) statements to civilians and others to the effect that he "wanted to go on foreign duty and be killed"; (5) threats to leave camp even when informed that charges would eventuate if he violated restrictions; and (6) inability to be "reasoned with" even when his demands were in excess of privileges allowed others.

Past History and Background. The patient is one of two siblings in a home of average economic status. He had little to say concerning his father except that they got along well together. The mother (seen in interview) is a rigid-appearing woman who refused to concede that her son's behavior was anything but perfect. She united with him in his belief that he had been unfairly treated and stated that "if the army did not want him, he could return to her; she was still his mother and loved him."

The patient's early development was essentially normal. He continues to bite his fingernails as a "result of nervousness inherited from the mother," but displayed no other childhood traits considered to be psychoneurotic predeterminants. In contrast to his sibling, patient was "always a model youth" who, if anything, was too eager to please others, particularly his mother." He graduated from college at about the usual age and made average grades. He was employed at various jobs during the summers and had a good work record. He came directly into the army from college.

Dynamics. Patient revealed that he has always been closely bound to his mother and that his behavior has largely been prescribed by her demands. His associations were largely with boys. He avoided close friendships with girls because of the attachment to his mother. On entering the army, he experienced his first real freedom, drove a car for the first time, met a girl with whom he fell in love, and experienced his first sexual relations. He felt inferior and inadequate when placed in command of others his own age or above. He also felt immature and childish before his fellow officers and sought their approval in much the same way he had that of his mother, i.e., by "giving" or "sharing" his possessions. When his efforts at adjustment proved to be inadequate and his activities were restricted, his reactions were of an immature, petulant nature. In the hospital, he insisted that he should have been allowed unlimited freedom and that he would have been justified in leaving the post against orders. Efforts to discuss his problems in a rational manner were resisted to the point where he claimed that "even under battle conditions it would be proper for a junior to question his (the patient's) orders, since everyone, no matter what the circumstance, had a right to do as he thought best."

*This and cases 13, 21, and 63 reprinted by permission from The Journal of Abnormal and Social Psychology, published by The American Psychological Association, Inc.

In summary, this officer displayed traits which indicated a lack of self-confidence and tendencies to behave in a dependent manner toward others. He reacted to reasonable restriction with outbursts of crying and sulking. The etiology appeared to reside in the emotional relationship to the mother. This took the form of acceding to her demands and wishes when in her presence (at home and in the hospital) and rebelling against them when away from her (while on active duty). The behavior itself created a situation in which there was either actual or a threatened breakdown in the "chain of command." In addition, his attitudes were apt to affect the morale and behavior both of his associate officers as well as the enlisted personnel. From a military standpoint, this creates an intolerable situation in view of the potential dangers it implies to the larger unit and to the accomplishment of military objectives.

CASE 3. Grown-up "spoiled child." Southard and Jarrett (3), p. 107.*

Mark White is now nearing thirty-one years, but strikes one still as a rather overgrown boy. He is rather an inferior-looking shipping clerk, who came of his own initiative to the Psychopathic Hospital. He said he was afraid of crowds and that his memory was not as good as it had been. He dated his troubles from a time when his express wagon had run into a street car and stunned him. He had a damage suit brought after this accident. He told of hallucinations of several sorts, the absurdity of which he said he now realized. Once he had thought a doctor had hypnotized him. He had very peculiar ideas about masturbation, which he said that he had done as a rebel against God and to displease God. The patient was a Roman Catholic. We found him to grade at 16.5 years on the Point Scale and to show few failures except in the memory tests; but in his memory he was more erratic than actually deficient. The question was raised whether he might be a psychoneurotic, or possibly a victim of dementia praecox.

A study of his family relations showed that he had been for many years rather extraordinarily dependent upon his doting mother's care; but she had died four months before he came to us. Up to this time he had been thrown only in the society of women of his mother's age and had made no friends among his own sex or amongst younger women. He was a sort of overgrown, spoiled child, a rather seclusive and very self-accusatory person. As for the hallucinations above mentioned, it is a question how gravely they are to be taken in the matter of the diagnosis of schizophrenia (dementia praecox). Certainly the notions about hypnotism and about masturbation are peculiar enough to suggest schizophrenia, and the so-called ideas of reference (people pursuing him on the street) might be used in building up that diagnosis.

He was discharged to the social service without a definitive diagnosis between schizophrenia and psychoneurosis. The ideal in such a case as that of Mark White might be to give him, in a popular phrase, some sort of "sublimation." The best social service could do appears to have been to give him compensation. A landlady of maternal type was secured through a room registry. Upon due explanation of Mark's plight, the landlady undertook his care. A position was found. The end crowned the landlady's work. Mark is now at least as well off as ever, perhaps better. Latterly he has even developed some fresh continguities and interest in women of his own age. He became particularly interested in the nurse who took him through influenza. Formerly made fun of where he worked, he has now become well liked and sociable both with men and women of his own age. The socializing problem is going apace with the aid of church measures, the community chorus and the like. Aside from irritabilities at the doctors, Mark White seems to be approximating the normal.

*This and cases 5, 59, 60, 67, and 87 reprinted by permission from The Kingdom of Evils by E. E. Southard and Mary C. Jarrett, published by The Macmillan Company.

Briefly analyzed, Mark White appears to be a threefold case of social difficulty in which neither moral nor legal difficulties appear. His medical category must remain in doubt; but there can be no doubt that he is in some sense psychopathic. His curious upbringing and maternal spoiling form an equally prominent part of the story; indeed some might claim that the medical difficulty traced absolutely and entirely back to his curious home environment He was economically in the need of aid during the first months of observation, coming to us as an object of charity, with the history of being in debt and of having received aid from a relief society.

Hours spent by:
- Physician, 9½
- Psychologist, 1
- Social worker, 57½

Medical record, 42 pages
Social record, 38 pages
Social work:
- Visits, 26
- Interviews at hospital, 13
- Telephone calls, 55
- Letters, 25

CASE 4. Epidemic hysteria, incident to sinking of "La Provence," Ross (4), p. 32.*

When "La Provence" was torpedoed we were able to study the manifestations of emotion close at hand apart from any commotional state.

We found that the pithiatic (hysterical) phenomena did not occur till later when the survivors were in safety. These phenomena yielded to an energetic treatment which was immediately applied, and did not recur during the week which followed the accident. Our experience was divided into four periods.

1st period. On board the boat seventeen minutes between the explosion and the complete disappearance of the boat—period of pure emotion. The crew were anxious and dumb. No cries. Many were in a state of agitation. Later an officer shot himself through the head. This was followed by a small epidemic of suicide. There were however no fits, convulsions or paralyses. In seventeen minutes there was nothing left on the water but wreckage, swimmers and drowned.

2nd period. In the sea for eighteen hours. Seventeen of us clung to a raft during this period. At first there were some expressions of despair but a cheerful fellow pulled them together by saying he had often been in a much worse hole and was sure he would get out this time. One man began a religious lament which began to upset others, but the officer told him if he did not keep quiet he would throw him into the water. None of the men died.

3rd period. After eighteen hours we were picked up by a torpedo boat and when all were on deck I inspected them. Several now showed neuropathic phenomena, quadraplegia, paraplegia, mutism, snarling, weeping, barking, shaking amounting to spasmodic movements of the upper limbs. I sent them down to the engine-room close to the engine where the temperature was very high. The number of my patients increased as new survivors arrived so that out of six hundred picked up there were about forty showing nervous disturbances.

The treatment was simple. They were stripped naked in an overheated room and energetically rubbed by two vigorous sailors with a hair glove soaked in alcohol. As soon as they had been warmed externally and internally with rum, I took each one separately and smacked him harder and harder until the disturbances disappeared, all the time speaking kindly to them and expressing my delight at the rapidity of their recovery. No one resisted more than ten minutes: many were cured of contagion on witnessing the treatment of the others. The majority expressed to me their gratitude on witnessing the treatment of the others.

4th period. I was able to see my patients for a week and there were no relapses.

*Reprinted with permission from War Neuroses by T. A. Ross, published by Williams and Wilkins.

CASE 5. Occupational neurosis. Southard and Jarrett (3), p. 151.

Herman Simonson left his family in a little village of Russia ten years ago and came to America to advance his fortunes. He lived frugally and uprightly and was a man of high character and some education. The work he found to do, clothes-pressing, paid good wages, but yet not more than enough to keep him and support the family in Russia—his wife, six daughters, and the wife's aged parents. As the years passed, he began to fear that he could not earn enough to bring them over; they were growing restless and hard feeling began to creep into their letters.

In the end Simonson acquired a severe neurosis with pains in the legs that became unbearable when he worked at his trade, and deprived him of strength to operate his pressing-machine. When he came to our out-patient department he had been the rounds of a number of general hospital clinics without improvement. His legs were cold and blue in spite of the five pairs of stockings he wore. His mental state was one of utter despondency; if he could not get well he could never see his children again; he had lived for them and now they had not enough to eat in that little Russian village and he could earn nothing to send them; would it not be best for him to commit suicide while his life insurance was paid up? If he could not be cured, almshouse life, never to see his wife or children again, was a fate tragic enough. He was cured after three years of persistent work. He first and last resisted treatment, wanted to try another doctor, objected to every kind of light work suggested and found fault with everything the social workers did for him, but was restored to competency, one might say, in spite of himself.

It was decided that the best prospect of making the patient self-supporting lay in setting him up in business in a small store, and a sum of money was raised for this purpose. After many attempts to find a store that would be a safe investment, an opportunity for trading in coal was arranged. Meanwhile a number of temporary occupations were tried, which the patient would give up after a brief effort. He was under treatment as an out-patient continually, and for six weeks was in the hospital as a voluntary patient. He complained that the doctors did not help him; thought that the lodge members who were obtaining financial support for him were adding to their reputation as charitable individuals by helping him; claimed that the money raised for him belonged to him and should be given to him unconditionally; repeatedly said he suffered "every minute of the day" but had not the courage to kill himself, though he would if it were not for his children.

As the pains in the legs decreased and he admitted feeling better, we insisted that he take a position as porter in a small factory in order to prevent his becoming completely disused to work. This was a job that he considered beneath him, and it paid only ten dollars a week, but it was the only thing open that he could do. He still holds on to this job at higher wages, although he has since developed the coal business. In the factory he is regarded as a man who must be humored, for everybody near him must hold his opinion or none. The foreman sums him up, "Well, you know, he's Simonson!" He has been elected president of a benefit organization to which he belongs. He is said to be "as cranky as ever" but is alert and in good spirits.

We analyze Herman Simonson as a binary combination of medical and economic disorder. We regard him medically as belonging to the psychoneurotic group of disorders. His fleeting pains, his rounder's history in several hospitals without relief, and his constipation were features. Whilst in hospital he woke up five or six times in the night worrying about his family in Russia. He felt cold sensations in the legs and sometimes had prickling sensations in the calves of both legs. Sometimes his hands were overwarm and sweating. He complained of a bad headache. He was neurologically normal.

The impression which Simonson conveyed to the physicians was one of relatively hopeless psychoneurosis. Accordingly, when it proved possible to get several hundred dollars to set Simonson up in business there was considerable concern expressed by the physicians lest the money was being thrown into the sea. The results above described speak for themselves.

It is worthy of particular medical inquiry whether there is any adequate and obvious physical cause for such a psychoneurosis as Simonson's. Cases numerous enough in this collection yield no such physical cause, but the failure to find such on the surface does not mean that such may not really exist. Moreover, there may be a kind of psychoneurosis due to special physical causes working directly or indirectly upon the mind. Thus in Simonson's case it may be inquired whether the steady, hard work and confining work at clothes-pressing with its persistent cramped postures may not have worked after the manner of the so-called occupation neurosis. The best example of occupation neurosis is, of course, the familiar writer's cramp, but even in writer's cramp there is an admixture of physical with psychic conditions, a mixture not always easy to analyze.

CASE 6. Occupational neurosis. Wechsler (5), p. 210.*

I. F., an unmarried woman of thirty-two, complained of inability to write with the right hand and difficulty in writing with the left. The condition in the right hand began in 1915. At that time she was a student at college. Just before graduating her right hand "became foolish," she lost the power of writing with it, and had to learn how to write with the left hand. She ultimately got her degree. Following graduation she worked on and off at various social and clerical postions, but could not make a success of her work because of her difficulty, though she learned to typewrite well. In 1925 she returned to college for her master's degree, but before taking the examination in the Spring the left hand went back on her and then she couldn't write at all. She was a very sensitive and not very sociable girl, who made little contact with men and had no sex outlet, much attached to her mother, and not so close to her father who was a cold, conservative man. The patient was analyzed for six months and it appeared certain that the difficulties with the hands were hysteric conversion phenomena. There seemed to be intense unconscious attachment to the mother who was left-handed, and the interpretation was that the loss of power in the right hand was an identification mechanism, at the same time that it was an unconscious punishment for masturbation with that hand. The onset of the difficulty each time that she was about to take final examinations for a degree which would prepare her for a career fitted in well with the psychogenic explanation that she wanted unconsciously to escape the need of relying upon herself, and her whole infantile reaction to life only confirmed that view. Despite the prolonged analysis and the bringing to the surface of mental mechanisms which confirmed beyond a doubt the hysteric nature of the patient, she failed to improve and was discharged from treatment. She returned in May, 1926 with the complaint that, beginning in March, the fingers of the left hand began to wiggle spontaneously, that the hand and arm moved involuntarily, that she had difficulty in using a knife and fork, and that she could not hold a cup without spilling its contents. She related that she had the "flu" in February of the same year and that she felt drowsy and sleepy for some time after the fever subsided. The suspicion of encephalitis was at once entertained but physical examination failed to confirm it. However, the abnormal movements were definitely athetoid and dystonic in character and there was not the slightest doubt of their organic nature. The right hand, too, began to show similar abnormal involuntary movements. The question then arose whether the original difficulties were altogether hysteric conversion phenomena or whether they were the forerunners of a definite organic disease of the brain which took

*This and cases 14, 15, 16, 18, 25, 27, and 74 reprinted by permission from The Neuroses by Israel S. Wechsler, published by W. B. Saunders Co.

years to develop and were mistakenly regarded as psychogenic. There still remained the rather remote possibility that the loss of the ability to write was indeed hysteric in nature and the subsequent athetosis and dystonia independent sequels of the acute "flu" which may have been an unrecognized encephalitis. Of course the organic disease might conceivably, by pure chance, have involved the very parts of the body which were also hysterically affected, but it is a fact of experience that cases of dystonia are for years regarded as hysteria and the correct diagnosis is made only after prolonged observation. In any event the case herein reported illustrates the difficulties of diagnosis even after extensive investigation.

CASE 7. Hyperesthesia, anesthesia, and analgesia. Eder (6), p. 21.*

A corporal, aged 37, who after 16 years in army service, had rejoined, and was wounded in May, 1915, in the right forearm, left nipple region, and elsewhere. The wounds were superficial and had apparently quite healed, but the site of the wound on the chest remained painful. Some months later the scar over the left chest reopened, and when it again healed the pain over the scar was so severe that he was unable to carry his equipment. When examined some eight months after the original injury he presented a scar 3½ inches long, running along the fifth intercostal space, with its inner end 2 inches from the sternum. The scar and the skin immediately adjacent were acutely tender to pressure—he could not bear the slightest touch here. To cotton wool touches, universal anaesthesia, save for a small area below inguinal folds on both sides, a patch 1 inch below and external to angle of left scapula. To pin pricks universal analgesia except (1) just below left scapula, (2) over scar and area 2 inches below it, (3) two small areas in lower abdominal region on a level with scrotum.

It will be seen that the anaesthesia and analgesia were almost complete and that the zone of hyperaesthesia was strictly limited to the area of scar.

Joint sense normal. Pupils normal. Smell normal. Hearing, contact L., Rt at 3 inches. Vibration sense lost in lower limbs, normal elsewhere. Reflexes: right plantar absent at toes and thighs (were present at a later examination); the left normal; abdominal reflexes, lower absent—the other reflexes normal.

There were no other symptoms; there was no other indication of disease of the nervous system. The scar and the skin adjacent were removed by operation in February, 1915; the wound healed by first intention. The operation did not alter the condition. The pain was still present, as were also the analgesia and anaesthesia. About a month later, ten months after the wound had been received, the patient was treated by suggestion under hypnotism. At the second sitting the symptoms entirely disappeared; the normal sensation returned in the analgesic area. For several days the corporal was rather dubious about the pain not returning, and he went through various manoeuvers to assure himself that he was now all right. There had been no return when he left the hospital some time later.

CASE 8. Deaf-mutism with paraplegia. Yealland (7), p. 48.†

A non-commissioned officer, 30 years of age. Duration, 2 months. On his return from patrol duty and when about to leave his trench to visit a bombing post, a shell burst behind this patient. He remembered being thrown from one side of the trench to the other. "It seemed like cartloads of earth being thrown in upon us." The next thing he remembered thereafter was pain in the legs when

*This and cases 10 and 12 reprinted from War Shock by W. B. Eder, published by Wm. Heinemann, London. Permission requested.

†This and cases 9 and 11 reprinted by permission from Hysterical Disorders of Warfare, by L. R. Yealland, published by The Macmillan Company.

he regained consciousness in an ambulance as it travelled over rough roads. When he arrived at the dressing station he could neither speak nor hear; there was pain all over the body, and the lower limbs were completely paralysed. He had been previously treated in a hospital in France for "paralysis of the legs" following a bombing raid, but returned in three months' time to his unit "perfectly fit." However, he had only been back at his unit a few days when the condition recurred as described above.

On admission to the National Hospital he was ready to write and appeared mentally active, for when I approached him he immediately began to write on a pad which was beside him for such purpose. He was emotionally unstrung and his whole expression was one of fear.

There was considerable loss of bone conduction over the bones of his skull, and also diminution to pinprick over the whole of the body below the first rib. There were no signs of organic nervous disease.

After a physical examination had been made I wrote: "You will be cured very quickly. Your condition has been entirely due to nervous exhaustion, but you have recovered from that as you have been resting two months, and now there is plenty of reserve nervous energy. The principal disorder which remains is that of deafness. You cannot talk because you cannot hear yourself speaking. When the hearing has been restored you will speak almost instantly. The helplessness of the legs is part of the same condition, but the legs are well nourished and the muscles are strong. I want first of all to cure the deafness; after that the recovery of all the other symptoms will be rapid. You must understand what I mean, read this over and over until you remember every detail. Just remember this: first, it is a curable condition; secondly, it responds very quickly to electrical treatment; and thirdly, the deafness recovers first almost instantly. You will be hearing and talking in a few minutes. Do you follow and do you understand?" He replied by writing, "Yes, sir," and also by nodding his head. He attempted to write further, but I did not allow him to, taking the pencil from his hand. Then he began to cry, and I had him taken to the ophthalmic room in that emotional state. The paper on which the above was written was in his hand and I made him constantly read it.

A faradic battery was employed to which was attached a button electrode. I applied short shocks over the right mastoid and after each faradic application held a watch firmly against his ear. After a few applications he held the watch himself to his ear and laughed hysterically as he nodded his head, meaning that he heard it. He attempted to write, but I did not permit him; instead I said, "I know you can hear the watch ticking without your telling me. You will now be able to hear what I say." Orders were next given him to perform movements, and I gradually diminished the sound of my voice until he could hear a whisper. No attention was paid to the other ear.

The patient was then ordered to say "ah," which he did, and appeared grateful and became demonstrative. I told him there was no time for such a scene and left him until he became less excited. When I returned in ten minutes he could talk and hear normally.

Before he returned to his ward I said to him, "Your legs will recover themselves." However, he apparently did not believe me, for in three weeks there was no change in the legs. He asked me one morning when was I going to treat the legs, and I at once decided to apply gentle faradism by means of a roller electrode up and down the legs for a minute or so, during which time I told him to perform movements at hips, knees, ankles and toes. He was re-educated to walk in a very short time.

In this case I concluded that the patient for some reason was not anxious for the legs to recover without electrical treatment.

CASE 9. Aphonia. Yealland (7), p. 23.

A private, 28 years of age. Duration, 2 months. This patient spent several days in the trenches during a severe bombardment on the Somme. A bomb exploded on the parapet, blowing him backwards and burying him to the neck. He succeeded in crawling out himself, but remained in the trenches to carry on "look-out" duty until the following morning. The next night, when in a dug-out, he had severe headache and pain in the eyes. He went to sleep there, and came to his senses in a hospital at Étretat eleven days later. The legs were weak, he had difficulty in hearing, and was not able to talk above a whisper.

One month later when I examined him he could walk and hear without difficulty, but he could not phonate. There were no signs of organic nervous disease and no functional anaesthesia. The back of the throat, however, was somewhat insensitive. The mental condition was good. No previous attempts had been made at treatment. The short duration, together with the fact that he had not previously been treated, indicated a rapid restoration. The fact that his mentality was satisfactory showed that firmness alone was necessary. I said to him, "Your voice will come back in a short time of its own accord, just as the hearing and weakness of the legs have been restored by rest. You need rest. You may decide for yourself whether you wait for time to heal you or whether you would prefer an immediate cure. Your voice will recover with treatment in less than a minute if you wish to have it cured.' He replied, "I prefer to have my voice returned as soon as possible." A small faradic battery was used and a key electrode attached. I said, "You will say 'ah' as soon as you feel the shock." I applied one shock of strong faradism to the neck over the larynx, when he at once shouted out and began to talk normally without re-educative measures.

CASE 10. Paraplegia (wish-fulfillment). Eder (6), p. 71.

In No. 10 the paraplegia was a wish-fulfillment. This patient was invalided to Malta for mild frostbite in the toes of the left foot. During this treatment he suddenly lost power in the left lower limb; on being transferred to an infectious diseases hospital (for scabies) he lost power of the right lower limb. On examination seven weeks later there was a stocking analgesia of both lower limbs, which were somewhat rigid. There was a rapid clonic tremor of the anterior thigh muscles. All the limbs could be moved moderately as he lay in bed. Gait feeble and shuffling, using two sticks and almost bent double. Knee jerks exaggerated, with tendency to right ankle clonus. Plantar reflexes absent at toes. All muscles reacted normally to faradism.

On December 31st the patient was dressed, waiting in the hospital grounds for embarkation to England, as a cot case, the left leg being useless. He had reported the scabies that morning. Then the order for embarkation was cancelled; he was carried back to the ward and transferred by ambulance the next morning as a "walking case" to the infectious diseases hospital. He was able to hop into the ambulance, but at the other end, some twenty minutes drive, he was unable to walk, the right leg had lost all power in the interval.* He thought he was not receiving proper attention, and wanted to show that he really was ill. Hence the paraplegia. It was not malingering; the analgesia and the alteration in the reflexes showed this, as did the patient's gallant attempts to walk. Under hypnosis,

*It was of course quite in order that he should go to England as a cot case—this meant he would be carried from the ambulance on to the lighter and thence to the hospital ship. And of course he was quite suitable as a walking case for transfer from one hospital to another.

although complete movements of the legs were obtained, walking could not be suggested; after the second seance, when he had managed a couple of steps unsupported, he had an attack of "grande hystérie." It was under hypnosis that he expressed the thought that it was unfair to send him as a walking case when the day before he was a "cot"—and his leg was no better.

Hypnotism was given up, as the patient was not making any improvement; instead I made an appeal to him, rousing an emotion that ended in a flood of tears. He lay awake all that night making up his mind that he would walk, and the next day the sticks were relinquished; he was cured of the paraplegia. The analgesia had been progressively disappearing in the way typical of hysteria. The reflexes became normal. The recovery was helped here by the presence of another paraplegic (hysterical) No. 12, who had been subsequently admitted to an adjoining ward and had made a quick recovery.

CASE 11. Tremors, stammering, seizures. Yealland (7), p. 187.

Private, 19 years of age. Duration, 5 months. A shell exploded some twenty yards from this patient when he was in the trenches at Arras. He immediately began to tremble, and the following day had three fits. The patient was taken to the C.C.S. and then to a hospital at St. Omer, where he remained a few days until his transfer to Rouen. Subsequently he was sent to England.

Two months after receiving the damage the patient was discharged from the Army.

On his admission to the National Hospital he was very tremulous and stammered. When he was walking the tremor was more marked than when resting; his body shook, the head nodded, and he held himself tense. There was a relative analgesia in the lower limbs to a line drawn round the root of the thigh. Signs of organic nervous disease were not present.

During air raid nights in September and October, 1917, he began to shake more violently than ever and had a series of functional seizures.

One evening I was called to see the patient, who was in a fit; he was being restrained by two fellow soldiers, and a nurse was holding a tongue depressor in his mouth. He was struggling violently, his head being turned backwards and to the right. His skin was covered with profuse perspiration. The patient was told to sit up, but he paid no attention to the order. Supra-orbital pressure was applied, and he was again ordered to sit up. In less than a minute he sat up, looked dazed, and began to rub his eyes.

I said to him, "Would you like to have your fits cured?" "Yes, sir," he answered. So I went on, "You will be seized by another fit in a few minutes. I shall bring an attack on by a mild current of electricity and cure it with a very strong current." When the battery was arranged I said, "I shall apply gentle faradism to the sole of your left foot; your trembling will increase to such an extent that you will have no control whatever over it. In other words, you will have what you call a fit." Faradism was applied by means of a roller electrode, the tremor increased, and his body went into violent clonic spasms. Then I said, "Now I shall cure the fit by the application of a stronger current." I turned on the current full strength and applied it to the front of the neck, telling him at the same time to sit up and stop his shaking. In a minute he was sitting up, but looked dazed. I applied another strong faradic shock to the abdomen, ordering him at the same time to "Look bright." He was still tremulous, however. "Now," I said, "I shall treat the tremor and the stammer, and when this has been accomplished I want you to walk and also to remember that the fits are permanently cured, you will have no more."

I then placed the pad electrode just below the front of the right knee, and, using a roller electrode, applied gentle faradism up and down the spine, ordering the patient at the same time to keep himself steady. The tremor subsided to a marked extent, but a fine tremor persisted in the fingers. With the arms stretched out in front of him I applied the roller electrode quickly up and down one arm, then the other, ordering, "Keep your arms more still, more still," etc., until the tremors disappeared. The pad electrode during this time was over the dorsal spines.

When the upper limbs were steady I applied faradism in the same way to the lower limbs until movements could be performed without any tremor. By this time the stammering had disappeared. I ordered him to walk and he did so normally. His mental condition completely changed. He remained in the hospital for two months after this, and up to the time of his discharge there was no recurrence of the fits.

The patient received fifteen minutes' treatment.

CASE 12. Auto-mimicry. Eder (6), p. 48.

No. 20, aged 21, of four years service, was admitted on March 14, 1916, to hospital, Malta, with a diagnosis of traumatic epilepsy.

The following history is as given by himself. In the middle of November, at Gallipoli, he was wounded in the left side of the head and at the back of the head by a piece of shrapnel. He was unconscious for five days and woke up as he was being taken ashore at Alexandria. On awaking he had to satisfy himself by looking and touching that he had not lost his right arm and leg. He had no feeling in those limbs and was unable to move either the arm or leg for three weeks; the leg gradually got better and then the arm began to improve. He states that he stammered for some days. Two operations were done upon him (nature unknown, probably not of surgical severity). He remained in hospital till the end of January, the first weeks in bed. He suffered a good deal from headache (frontal). On leaving the hospital he says he was able to walk, but the right leg was weak; he had no power or feeling in the right arm. From Alexandria he was sent to camp in Mudros. Here he had three fits.

1st. About first week in February, 1915, when, after a little dispute, his "head went dizzy" and he lost himself. The orderly told him he was violent; he does not know how long the fit lasted; it was followed by a headache.

2nd. About February 20, he was in a billet with some others when again, after a little dispute, his head was dizzy, he had a buzzing in both ears, and on awaking recalls being slapped by a doctor.

3rd. At the beginning of March, in the same place, he was repairing a telephone and was being "hustled" by the driver of a motor-lorry outside; again felt dizzy and buzzing in the ears, and remembers doctor's presence on his awaking.

In none of the fits was there any incontinence of urine, nor did he hurt himself nor was the tongue sore.

Only after the first fit did he speak of a headache following the attack.

Examination: Patient is a right-handed man of powerful physique; speech and articulation normal.

There is a small circular scar, $\frac{1}{4}$ inch, over the left temporal region, $\frac{1}{2}$ inch behind Rolandic line and $2\frac{1}{2}$ inch vertically above tip of left mastoid.

Pupils and cranial nerves are normal.

The fundi are normal, as are the visual fields.

There is anaesthesia and analgesia of the right side of face to middle line, of the whole of the right forequarter and of the right lower limb from the toes to a hand's breadth above patella.

Though patient does not feel the pricks of a pin (the pin can be driven and left in the skin), when told to place his left hand (the eyes being shut) on spots indicated by the examiner's hand, he is able to locate with his hand the area so touched. Grasp of right hand is feeble; the leg appears of normal strength.

Joint sense deficient in fingers, wrist, elbow, shoulder and toes of right limbs.

Astereognosis: fails to recognise hair-brush, knife or key in hand or foot.

Gait normal.

The right hand cannot be used, e.g., cannot hold a spoon, fork, or cut with a knife.

Reflexes: supinator and ankle jerks are present. No ankle clonus. The plantar reflexes are present. Abdominal reflexes are present and equal.

The muscles of fingers and wrist react normally to faradism.

X-ray examination showed a piece of metal in the diploe immediately beneath the scar.

A diagnosis of hysterical (functional) anaesthesia and paresis of the right hand was made from the distribution of the analgesia and the electrical reaction. The fits were concluded to be hysterical.

But that the patient had had a temporary organic hemiplegia immediately following the injury is clear from (1) history, especially his looking and touching to see if the limbs were present. In my experience this is unusual in purely hysterical conditions, in accordance with what would be expected from the psycho-pathology of this condition. (2) The site of the injury as shown by the presence of metal. (3) The disorder of speech (stammering) immediately after the injury.

On March 16 suggestion under hypnotism was carried out, when the analgesia disappeared from face, right shoulder, and leg.

March 18, second treatment by suggestion under hypnotism, analgesia confined to forearm.

March 23, complete disappearance of analgesia and recovery of use of hand.

The patient remained perfectly well from April 9, when I last examined him.

The diagnosis was confirmed by Col. Purves Stewart, A.M.S., consulting physician, and by Col. Thorburn, A.M.S., consulting surgeon to the Malta command, who also agreed with me that surgical interference was unnecessary.

The first hemiplegia was presumably due to a haemorrhage, following the shrapnel wound; this rapidly cleared up and was succeeded (apparently without a break) by the functional hemianaesthesia and paresis.

CASE 13. Hypochondria; psychosomatic hysterical symptoms. Layman (2), p. 161.

This is a 31-year-old first lieutenant, who complained of abdominal pain at the time of admission to the hospital. He had been subject to this distress for some four or five years; however, the present attack was more painful and associated with nausea followed by a "crampy," intermittent pain around the umbilicus. Thorough study on the Medical Service proved to be negative and resulted in a request for consultation by a member of the Neuropsychiatric Staff. He was transferred to the latter service as a result of this consultation.

Past History. The study of this patient revealed that he had a long history of problems centering in his feelings about himself, his bodily functions, and his interpersonal relationships. He had transferred from a rural to urban school

where he felt himself to be "the country bumpkin with the hay seed still in his ears." He felt that all the "kids picked on him" but had no trouble with school subject-matter itself. He was "shy, tongue-tied, feared snakes and high places, had difficulty with his breath and if he fought with anyone, he had to win in the first few minutes because he soon became excessively fatigued." The patient had the usual childhood diseases as well as pyelitis and nephritis. At the age of 13, there was an unusually rapid spurt in growth. As far back as he could recall, he had always been bothered by periods of backache, headache, and diarrhoea. The social service data indicated that the patient "was always rather highstrung, had his own way during most of his early life, had been pampered by his mother (markedly so during periods of illness), and that he had had several unsuccessful love affairs."

After the patient graduated from college, he chose occupations which enabled him to adjust to his symptoms; that is, where he could work rather strenuously for a period and then "take a vacation." The work itself was well performed and he received steady salary increases. Also, the firm which employed him valued his services sufficiently to request his deferment. The patient finally enlisted voluntarily. His talents were recognized and he was early recommended for an Officer's Candidate School. His senior officer stated that the patient "was able to learn faster than any other officer who had previously been given the same responsibilities," rated him in the upper third of all officers he had known in the service, and said "that he accepted responsibility readily and followed assignments through vigorously."

Dynamics. Interviews with this patient revealed the following: Acceptance of his symptoms without too much concern so long as he had been able to adjust his living conditions to them; strong identification with the mother; early homosexual experiences which, he claimed, produced no feelings of guilt; attempts to establish more satisfying relationships with the opposite sex which were never satisfied because he "put his ideals too high and wanted someone like his mother"; avoidance of heterosexual experiences because they were not aesthetic before marriage (he illustrated this by saying that he avoided prostitutes because he "did not like the idea of having to watch the front and back windows for policemen"); concern over the fact that he became sexually aroused whenever he had to mingle with others while in the nude (showers and barracks); and strong ambitions to get into a "top salary" bracket which he had been on the way to realizing at the time of enlisting.

It would appear that this officer's symptoms reside in his early childhood experiences. These seem to result from the unresolved oedipus relationship and its consequences, which reflects itself in sexual conflict. The "choice" of symptoms would seem to be based on his earlier experiences with illness, both imagined and real. These secured an intensification of attention and affection from the mother which made "illness" a not-too-distressing or uncomfortable situation. The patient described these recurrences of his illness as follows: There was a background of symptoms which he always recognized but which no longer concerned him unless he was not engaged in active work. He would tackle a job strenuously, get it completed, feel exhausted and then become aware of his various aches and pains when no longer so active in his work.

In this officer, we see a man who is highly intelligent, capable, and a good worker who met his responsibilities well. He possesses certain technical knowledge and skill which is of value to the army. The problem involved, from a military viewpoint, is chiefly one of regulating his duties in such a way as to prevent the episodic recurrence of his symptoms. This, however, is not easy to accomplish

under the demands being made on all military personnel. Instead, it will be necessary for the patient, himself, to recognize and control the conditions which produce his reactions so far as he is able under the circumstances. He has gained some insight into the psychogenic nature of his problem and plans to arrange for psychotherapy when this becomes possible.

CASE 14. Anorexia. Wechsler (5), p. 192.

L.S., a little girl of eight, was brought to the office with the complaint that she had loss of appetite, vomiting spells in the morning, especially if forced to eat breakfast, pains in the stomach, and twitching of the mouth; also that she bit her nails and was generally very nervous. The condition had lasted a year and a half, beginning at the time when the child entered school. It was first noticed that she walked peculiarly and that she would sit and rock a great deal in a chair. Then she began to complain of pain in the stomach, which the child discovered was relieved by lying flat on her face. The suspicion of appendicitis was entertained, and the child began to dread an operation. The history was that six months after the birth of the little girl and death of her mother the father remarried a woman some fifteen or twenty years his junior. The second wife had a little girl by a former marriage, older than the patient, on whom she showered, in invidious fashion, a great deal of affection. The patient did not know at first that she had a stepmother, but as she grew up and her older brother and sisters, whom the father kept at boarding school, came home she learned that her real mother was dead. She kept the secret to herself, but began to fear the stepmother who was unaware that the child had knowledge of the facts. The stepmother, unconsciously or otherwise, gave all her affection to her own child, but as a show of equal kindness to the little patient, who sensed the difference all the while, she smothered her with oversolicitousness. Thus she forced the child to wear clothes she did not like on the ground that health demanded them, compelled her to eat all kinds of food the child did not relish in order to strengthen her, made her stay in bed when the patient would rather have played, also on the ground that frail health demanded it. The father, too, sensed all this, though he had no proof, and naturally showed more than ordinary affection to the little girl who, in turn, was much attached to him. This engendered hostility on the part of the stepmother to the father, and it promptly registered on the child. As the father was away traveling weeks at a time the child dared not openly antagonize the mother and purposely kept to herself the secret knowledge that her real mother was dead. As time went on she became more and more acutely aware of the hostility between the parents, particularly after she once overheard her father speak of divorce to her oldest sister at a time when the latter came home from the boarding school. All this came to the surface when the child was alone with the examiner and after she was repeatedly assured that her mother will not be angry. The child dared not speak her mind to the mother in whose presence she protested, too much, it seemed, that she loved her. The psychology of the anorexia and vomiting became very clear to the father, but the mother protested against the interpretation. The father was advised to take the child out of the house, and the little girl recovered.

CASE 15. Insomnia; paroxysms of breathing. Wechsler (5), p. 195.

E.V., a school boy of thirteen, was brought with the complaint that he had spells of rapid breathing, puffing, and blowing, that he screamed at times, and used vicious language. He had been well and bright up to two years before coming to the office, when, following the death of somebody he knew, he began to suffer from

insomnia at night and sleepiness by day. He had no fever or any signs pointing to encephalitis. Following the onset of insomnia he began to have the paroxysms of rapid breathing, blowing and puffing, which lasted a few minutes at a time and occurred mainly at night. He became irritable and cranky, using abusive language to his mother whenever he was crossed. He discontinued his school work, so that by the time I first saw him he was retarded two years. The boy was an only child who lived with his mother, the father being separated from her. She was with the boy most of the day and slept in the same bed with him. For a short time the patient went to a radical country school with boys and girls much older than himself and he saw them bathing nude together. On questioning the boy he stated that he got pleasure from the spells, that they came on when he wanted to get even with boys who teased him or with his mother whenever she annoyed him, and could stop them if he wanted to. He related how boys who practised masturbation collectively tried to teach him how to do it, but he ran away from them. The same boys also told him "dirty things" about girls, which he did not like, but he could not help thinking of them all the same. On several occasions the boys played with girls and he even saw them touch their genitals. He thought of the girls all the time, particularly of one whom he loved. Although the mother was an intelligent and co-operative woman it was difficult to break the intense attachment between her and the boy, all the more as her own love life had been shattered. The boy was finally taken out of the home and placed in a private school under the guidance of competent teachers. He recovered completely.

CASE 16. Hysterical epilepsy. Wechsler (5), p. 218.

I. H., a tailor fifty-four years of age, complained of pain in the right side of the head and the left leg, headache, and spells of confusion and delirium. One week before coming to the office he slipped and fell down a whole flight of stairs, striking the right side of his head and the left leg. He was not unconscious and did not bleed from the mouth, nose or ears. He was taken home complaining of headache and pains. The next afternoon, and every day thereafter, he began to have the following episodes: He suddenly became confused and delirious, rambled incoherently and nonsensically, and shook all over. This lasted for an hour, then he became himself again, remaining well till the next day brought a recurrence. He had no recollection of what he said or did during the episodes, though it was evident that he was not unconscious. Except for apprehensiveness, excessive reaction to painful and other stimuli, and of the residual signs of contusion of the left leg and ankle, the examination revealed nothing abnormal. An X-ray of the skull was also negative. The family physician reported that he regarded the patient, whom he had been treating for years and years, as a neurotic, that he had been a struggling workingman all that time, and that his family life had not been happy. The patient was seen subsequently, but, except for a lengthening of the intervals between the spells, the condition had not changed. Litigation had meanwhile begun and he was receiving partial industrial compensation for his disability. Careful observation immediately before, during, and promptly after the spells failed to confirm the claim that they were "epileptic" in nature. The patient did not work for two years. While on the witness stand during the trial in court he had one such episode. The case was adjusted after that. There was no doubt at all of the hysterical nature of the condition. The trauma precipitated a neurosis which unconsciously served as an escape from the drudgery of work and the burdens of the home.

CASE 17. Hysterical epilepsy. McDougall (1), p. 399.

P., a well-developed man of thirty-five, complains that for some ten years he has been incapacitated by frequently recurrent "fits." These take two forms. When he is at home (he lives in his parents' household) he falls suddenly unconscious, sometimes with convulsive movements in the course of which he bites his tongue; and sometimes he bruises himself severely in falling. When away from home he frequently loses "consciousness" and wanders about, sometimes arriving at home still "unconscious." He comes to himself suddenly, and then can recollect nothing of the period of "unconsciousness." He has been told by several medical men that the "fits" are epileptic; and this has depressed him greatly.

P. is the youngest of three children. His father, who used to drink heavily but is now reformed, has always been indifferent to him. His mother, largely owing to her husband's drinking habits, has been very irritable and, when P. was a boy, used to vent her anger upon him, frequently beating him. She never beat his sisters. P. felt the injustice keenly. He can see now that his mother is sorry for her former ill-treatment of him, though she has never admitted it in words.

When P. was fifteen years old an elderly man seduced him, by means of liberal payments of cash, into participating in homosexual practices. After this had continued for some months they were both arrested; he was charged with indecent behaviour and discharged with a warning; the other man was punished. The facts became public property in his neighbourhood, and his young male acquaintances frequently "chipped" him on the subject; e.g., if he wore a new garment of any sort, they would say: "Hello! Have you been seeing your old man?" He suffered much distress in consequence and was isolated from all companionship; he felt himself unjustly treated on every hand and quite alone. There was no one with whom he could discuss his troubles. In early manhood he went through a course of training as a nurse, and took several private nursing jobs with success. One evening he attended out of curiosity a spiritistic gathering, and shortly afterwards he suffered his first "fit." He cannot recollect clearly what was said or done at the spiritistic meeting; but he seems to entertain vaguely a theory of possession and to regard himself as "possessed." From that time onward the "fits" have recurred about twice a week. He has been unable to obtain any employment and has lived at home dependent on his parents, doing odd jobs about the house. He is utterly sick of this existence.

In order to discover the content of his thinking during "the fits," I explored in hypnosis, which state was readily induced to a deep degree. It then appeared that during a "fit" he commonly seemed to be two people, e.g., as he walked along the street in a "fit" he was aware of a duplicate of himself following close behind him; in fact, he seemed to be out of his body and going ahead of it. On other occasions he saw in the "fit" a sinister figure (on some occasions a Chinaman) who seemed to enter into his body and displace him from control of it.

I was able to see P. only a few times, because the prime desideratum seemed to be a change from his unfortunate domestic environment and a new start in life in scenes remote from all associations with it. It seems clear that the fits, although in form so closely resembling true epileptic fits, were of affective origin; and that, like the typical hysterical fit, they served to secure a vaguely desired end, namely, to make his parents sorry for him and for their harsh treatment of him. This motive was unrecognised by P. and strongly repressed. Consciously he strongly desired to get the better of his trouble. An interesting feature of the case was that, on the days on which he had an appointment with me, he was generally seized by a "fit" in which he sustained injuries or disfigurements, such as a "black eye," which, but for my strict injunctions, would have prevented him from keeping his appointment with me.

CASE 18. Neurasthenia. Wechsler (5), p. 163.

O.A., a man of thirty, artist by occupation, complained of want of self-confidence, of being ill at ease among people, of lack of self-reliance, of inability to face life in general, and of incapacity to concentrate upon his work or to take interest in things. He slept poorly, tired easily and suffered from obstinate constipation. The condition dated back many years. He began to masturbate very early, indulged in the practice daily or oftener up to the age of twenty when he "let up" a little, but kept it up to his marriage one year before coming to see me. He rarely had sexual relations before marriage and never successfully before or since. His premature ejaculation, among other things, led to trouble with his wife, so that they separated. She taunted him for his want of manhood and he chafed because she had no respect for him. He worked spasmodically and often sought forgetfulness in excessive drinking. Despite his intelligence the patient failed to co-operate. He had never been to a physician before, came for consultation only at the earnest solicitation of a friend, and really showed no desire to get well. This is quite contrary to the general tendency of neurasthenics to consult doctors all the time and to become the victims of quacks who thrive on the myths of "weakened manhood."

CASE 19. Neurasthenia. Southard (8), p. 241.*

A harness-maker, 37, a corporal, was called to the colors on the second day of mobilization. He was attacked by a slight dizziness in the evening (see previous history below). He went into the field on August 7 and had repeated attacks of dizziness, despite which he took part in several skirmishes. He could not ride on horseback, since dizziness, ringing in the ears, headaches, and trembling of the whole body would develop. October 27 a severe fainting attack came while he was sitting on a horse. He woke ten hours later, vomited several times and felt dazed. Two weeks later hearing in the right ear began to be impaired. During several transfers from hospital to hospital near the East front, there were two more severe attacks of dizziness and vomiting. Brought back to Germany, the patient finally came to the Jena Hospital, May 20.

The estimate of this case depends somewhat on the previous history. He appears to have come from a healthy family, was married, and had two healthy children. His bodily and mental development had been normal; he had been an unusually good scholar, but he stammered from his tenth year without apparent reason. He had had treatment in an institution for stammerers at 17, achieving a complete cure in six weeks. His military service was as a cavalryman, 1897-1900, after which he had married. There was no excess in alcohol; he was not a smoker. From his own account, he had always been somewhat nervous, had trembled easily, and had fallen to stammering when excited. In 1913 there had occurred, after physical exertion, three violent attacks of fainting, with dizziness, vomiting, and excessive perspiration, each attack lasting from two to three hours. However, from that time to just before the war, he had been free from attacks.

On examination at the Jena Hospital, the patient complained of general weariness, a feeling of pressure in the back of his head, a hammering all over the head, ringing in the right ear, impairment of hearing in this ear, a feeling of dizziness on raising the head, palpitation of heart, especially at night, occasional trembling of the whole body, and absolute inability to walk.

The man was slenderly built, of medium height, in moderate nutrition; pale of face and mucosae; pulse small, regular, and 114. Neurologically, the deep reflexes were generally increased, and the skin reflexes decreased. Percussion on

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the back of the head elicited marked pain. There were no pressure points. The movements of the arms were free; there was a marked tremor of both hands, more marked on the right. The left grasp was 45, the right, 20, by dynamometer.

When lying upon his back, the patient could move his legs, but he moved them only slowly and with tremor. The heel-to-knee test was successfully executed despite the tremor; nor could it be demonstrated that there was a genuine ataxia. Placed upon his feet, he would collapse, nor could he be made to walk at all. With trunk supported, he was able to make only a few unsuccessful attempts to drag the feet forward.

Associated with this apparent paralysis, the sensitiveness to touch had entirely ceased in the legs, as well as sensitiveness to pain. The zone of analgesia, however, was more extensive than the anesthesia, spreading upwards three or four cm. farther in front. Ticking of the watch could not be heard even at the meatus of the right ear, although hearing of the left ear was entirely normal; bone transmission on the left side. Whispers could be heard close to the meatus. On speaking, the patient stammered in starting sentences.

He looked extremely anxious during the first few days in the Jena wards, claiming that he could not raise himself. When his trunk was raised, he would let himself sink feebly back into dorsal decubitus. However, when believing himself unobserved, he was found to be able to move himself in bed somewhat quickly. He was able to get a box from beneath the bed, to open the drawer of the night-stand, and to take remarkable care of his moustachios. He complained more and more of headache, though his appetite and sleep were good. He was often irritable.

Treatment at first consisted of cold packs of the legs twice a day, salt-water baths, active and passive exercises of the legs in the position of dorsal decubitus. The patient declaimed against this treatment. There was slight improvement after a week of treatment. He was then able to raise himself in bed, seat himself on the edge of the bed, and stand without support, all the time, however, groaning and moaning. After a few moments, he would fall back on the bed, complaining of violent headache and dizziness. While standing, both legs trembled.

CASE 20. Indecision; doubt. Bluemel (9), p. 46.*

Isador H., a middle-aged Jewish peddler, said he was so troubled by indecision that he could no longer believe his own eyes. He would turn the key in a door, then go back half a dozen times to make sure that he had actually turned it. When mailing a letter he could never feel satisfied that the letter had dropped in the mailbox. Often he would return to the mailbox and examine it, but this failed to relieve his doubts. After eating a meal at a restaurant he would return to make sure that he had paid his bill. When receiving his change at a store he would count the money several times. After putting his glasses in their case, he would open the case repeatedly to make sure that they were really there. When dressing he would put his arch supporters in his shoes, then take them out again to make sure he had already put them in. This was a daily procedure which he repeated a number of times. It was in this connection that he remarked his inability to believe his own eyes. When washing, he was never sure that he had washed sufficiently. The same doubt annoyed him in shaving, and after shaving he was never sure that he had cleaned his razor sufficiently. He could not feel satisfied that he had put a cork securely in a bottle and he could not assure himself by examining the bottle. He was unable to reach decisions in more important matters. In his work as a peddler he sold balloons at country fairs. When two fairs were held simultaneously he could never decide which one to attend, and when attending one he felt sure that he should have attended the

*This and cases 22, 24, 28, 51, 62, and 84 reprinted with permission from The Troubled Mind by C. S. Bluemel, published by Williams and Wilkins.

other. A similar situation arose in the fall when he sold souvenir footballs at football games. As a rule there were several games on the same day and he could never decide with certainty or satisfaction which game to attend. He was bothered by indecision in reading, and he would re-read paragraphs to make sure that he had read them and understood them. He was indecisive in his consultation with the physician and he would interrogate the doctor in a number of different ways in order to assure himself that he had understood matters correctly. After leaving the doctor's office he would often return to seek confirmation of what he had already been told. He displayed a tendency to mysophobia and he reserved his own knife and fork at the table. He would turn water faucets with a piece of paper and would wash his hands a dozen times a day.

CASE 21. Anxiety state. Layman (2), p. 159.

The patient was a 28-year-old captain in the Medical Corps who voluntarily requested admission while enroute to a new station. On admission he stated that he "had an all-gone feeling in the pit of his stomach," and felt "nervous, jittery, anxious, and panicky." He was moderately tearful and tense but otherwise did not overtly appear to be distressed.

Past History. The patient comes from a moderately well-to-do family where the mother is "high strung" and suffered from attacks which resembled syncope. As a child he was easily excited, vomited when he saw a fire engine or was in danger of being late for school, was overly conscientious, and felt terrified whenever his mother had one of her attacks. He got along well with others, made good grades all through school, and was rated as an excellent battalion surgeon by his associates.

Dynamics. The patient revealed that this was the third attack of a similar nature. The first occurred at a time when the first prolonged separation from his parents was impending; the second, when a change of station was made which involved being away from his wife for a period. The present episode developed when he was again separated from his wife. There was also the possibility of going on overseas duty on this latter occasion. While the underlying pattern of "need to be with someone on whom he is emotionally dependent" is obvious, time did not permit the study which would have made the reason for the "need" more clear.

In this instance, the reaction is of an acute "anxiety" nature with the usual somatic and visceral concomitants. The background or etiological factors of these cases, as one would expect, varies considerably. Their similarity resides chiefly in the overt behavior characteristics. To a large extent, it has been necessary to arrange for separation of these cases from the service. This is particularly true of those who are assigned to combat units and where such reactions might occur at moments where the behavior might have serious consequences to others.

CASE 22. Mysophobia. Bluemel (9), p. 24.

Mildred W., a bookkeeper and timekeeper, was seen in consultation when she was 33 years old. She was employed in a machine shop where the workmen would come into her office with greasy hands and would sometimes touch the back of her chair. Because of this fact she became dirt conscious. She was afraid to have anyone touch her clothing and she would sometimes put out her hands to keep people at arm's length. Once she found a grease spot on her coat and she spent several days trying to get it out. But the grease merely spread and this made matters worse. She got into the habit of examining her clothes for

spots and this search became a bedtime ritual, the ritual sometimes continuing till the early hours of the morning. After touching her clothes she felt compelled to wash her hands, and if she touched the chair on which her clothes had previously been placed she had to wash again. She was in constant fear of contamination and if she had to open a dresser drawer she grasped the handles with a towel. She made a practice of wrapping her hands and forearms in towels before putting on her coat, and she devised a method of spiral wrapping which permitted her to unwind the towels after she had put her arms through the sleeves. When removing her coat she exercised meticulous care to see that it touched nothing in the room. She made a point of hanging the coat on the highest hook in the closet, but even then she was worried lest it touch the floor. Reason told her that the coat would hang at least a foot from the floor but she found herself constantly verifying this by getting on her hands and knees and inspecting the bottom of the coat to make sure that it actually cleared the ground as she expected. All of this obsessive conduct was fraught with much agitation and distress. Often there was a struggle between reason and emotion, but emotion invariably dominated the situation. Treatment in this case consisted of psychotherapy and kindly discipline. Dressing and undressing were supervised by nurses, and the patient was not permitted to examine her clothes. She made a marked improvement in the course of two months and was then discharged from the sanitarium at her own request. As a precautionary measure she was advised to wear washable dresses, and as far as feasible to avoid silks and expensive clothing till the fear of dirt was permanently banished from her mind. In addition, she was counseled not to resume her former work, where she might again develop fear of dirt and contamination.

CASE 23. Irresistible fears. Kraepelin (10), p. 273.*

The case of an acrobat, aged thirty-five, will serve to show you the symptoms of irresistible fears in a rather different light. He was brought here yesterday by the police, to whom he had applied for protection when, having suddenly become apprehensive on a railway journey, he had left the train, and was wandering aimlessly about in the town.

As you will see, the patient is quite collected and clear, and gives connected information as to his experiences. We learn from him that nine months ago he fell 20 feet from a trapeze, on which he was performing, happily escaping with only a fracture of a metacarpal bone. But he fell on the back of his head, on which two non-adherent scars are visible even now. After the accident, he was unconscious for a long time. The third day after that an attack of convulsions was said to have occurred, which, however, was not repeated. Since his fall the patient suffers from apprehensive fears of a peculiar nature. As he relates it, the apprehension comes on, with violent oppression of the head, that he may, perhaps, blurt out indiscreet remarks, particularly lèse majesté, especially if he finds himself in a large company of people, although it is altogether contrary to his sentiments. Sometimes the apprehension becomes so great that he holds his pocket-handkerchief before his mouth so as not to speak, but yet he has never said anything really punishable. During the last year he has, from preference, performed abroad, where he had no fear of immediate arrest for an offence against the Emperor. Further, on closing an envelope, he had the fear regularly that he must spit into it, and for this reason left his letters to be closed by others. On the journey from Heidelberg to the South, where he was expected, he became ill; he lost consciousness, and, according to the statements of his fellow-travellers, also had convulsions. Then he was seized with great apprehension, and, fearing lest he should be arrested, got out and made for the river. The patient has very

*This and cases 33, 34, 43, 48, 76, 77, 78, 82, and 83 reprinted with permission from Clinical Psychiatry, 2d ed., by Emile Kraepelin, published by Wm. Wood & Co.

little information to give about this last occurrence, and, except for a rather depressed mood, presents no other psychical disturbance. Physically there is to be noticed a slight acceleration of pulse, and increased activity of the excitability of muscle, as well as of skin and tendon reflexes, also hyperaesthesia of the skin, especially under the stimulus of cold; the knee-jerk is much stronger on the left side than on the right.

In this patient, too, the fears might seem to have taken the form of impulses, but on closer examination we shall see that the patient does not really feel driven to the actions he fears, but that it is only the apprehension that he may, perhaps, do something of the kind which comes over him. The condition, therefore, differs from that observed in our first patient only in the fact that, in that case, the supposed danger threatened from without, while here it is expected to arise from the patient's own action. There are also cases, though fortunately they are not very common, in which we have to deal with actual morbid impulses to what, under some circumstances, may be extremely dangerous actions. In these cases the action is not feared, but is an object of pursuit, and the resistance to its being carried out arises not so much from feeling as from reflection; if the obstacles are once overcome, the action is followed at first by a certain sense of satisfaction. But our present patient never goes to the length of carrying out the actions he fears, and the possibilities which arise in his mind are always such as seem particularly repulsive or alarming to him, while in real morbid impulses the end seems desirable, however much rational consideration may be opposed to it.

The clinical interpretation of this case of disease presents no very great difficulty. The convulsive attacks, which appeared soon after the accident, and apparently were repeated a short time ago, might be regarded as signs of epilepsy. But the morbid fears themselves, the hyperaesthesia of the skin, the fact that the attacks passed off without causing injuries or tongue-biting, their close connection with the states of apprehension, and the absence of other signs of epilepsy, suggest that we have rather to deal with a psychogenic picture of disease, of which we may attribute the appearances partly to hysteria. The peculiar fears, however, are not actually diagnostic of hysteria, but they belong to a nearly related picture of disease—the insanity of irrepressible ideas, etc. This is also a form in which degeneration finds expression, and for that reason we fairly often meet with cases in which the phenomena of these two affections, and also of maniacal-depressive insanity, which springs from the same root, are combined with each other in the most various ways.

This interpretation of the case will prevent our attributing too much importance to the part the fall has played in producing the present disturbances. Even if the states of psychical weakness following on injuries to the head, which are totally different from what we have here, are left quite out of consideration fright neurosis itself presents an essentially different picture from that which we see in our patient. Instead of a general hindrance to physical and mental efficiency and an increased liability to fatigue, we meet with signs of illness here, which are often enough observed even where there has been no previous injury to the head. We may, therefore, conclude that, in the present case, the accident is not to be regarded as the real cause of the disease, but only as the occasion setting free its symptoms, of which the ultimate foundation is formed by the peculiar disposition of the patient. This conception is of great importance to our estimate of the future prospects of the case. While in the more severe forms of fright psychosis the disturbances only slowly, and in some circumstances never, pass away, we know that hysterical symptoms, though sharply defined as a rule, are usually extremely susceptible to influence and subject to change. Even when of very long standing, under some psychical influence, they may disappear as suddenly as

they arose. We shall, therefore, be able to count in our present case on producing a certain improvement by suitable psychical treatment. But as we are only able to remove the symptoms and not the hysterical predisposition, we must be prepared for the reappearance of much the same symptoms sooner or later, with or without an external cause.* This is more especially true of the irresistible fears, which do not come within the picture of hysteria, and show a great tendency to persist.

CASE 24. Obsessive thinking. Bluemel (9), p. 16.

Obsessive thinking sometimes focuses itself on the matter of the teeth. Mrs. D., a woman of 62, said that she had been preoccupied with her teeth since she was seventeen years old. As a child she had sucked her thumb and this caused her teeth to protrude. She became conscious of her teeth and would often examine them in the mirror. When she became interested in a young man, she went to a dentist to have her teeth straightened. The dentist put bands on her teeth but this failed to give satisfactory results. As time went on she consulted many dentists and she was always having her teeth treated or "adjusted." At fifty-seven years of age she had all her teeth removed but her predicament was as bad as ever, for she then worried about her plates. She had seven sets of plates made in the course of five years, but they were all unsatisfactory. Plates were too heavy, or ill-fitting, or unbecoming, and none of them afforded both comfort and peace of mind. When she secured a well-fitting plate she became critical of individual teeth and would examine them in the mirror. She worried about invisible and imaginary defects and would take her plates out and scrutinize them. Whenever she examined her teeth in this manner she became nervous and agitated. Her nervousness was accompanied by hot flashes and was often followed by a feeling of exhaustion. To add to her difficulties she was preoccupied not only with her own teeth but with other people's teeth. She felt impelled to watch people's mouths, and she made mental criticism of any dental defect which she thought she discovered.

CASE 25. Obsessive thinking. Wechsler (5), p. 173.

Mrs. M. S., a woman of twenty-seven, had the obsessive thought that hair was growing on her chin. She kept looking at the mirror and picking at her chin. She suffered from intense anxiety, stayed in bed most of the time and refused to go out because of the thought that hair was growing on her face. The obsessive thought first occurred to her at the age of twenty-two, four years before her marriage. She was a pretty, intelligent, sociable and popular girl, but the recurring thought kept her to a great extent away from the company of men. When she finally became engaged she confessed her fears to her fiance who laughed at her silly thoughts. On marriage it turned out that her husband was impotent, and, as I learned later, knew that he had been for a long time, but to cover up his own weakness he told the bride that his impotence was due to her undue resistance. As a matter of fact she had normal desire and had been masturbating for many years prior to marriage. She related the story that a man tried to assault her when she was a little girl of eight. Afterward she got the idea that she was not a virgin and for years the thought kept on plaguing her to such an extent that she

*We submitted the patient to a hypnotic treatment, which succeeded very easily, and removed all his complaints at once. Unfortunately, we could only keep him under observation for one week longer.

constantly dreaded the possibility of the discovery by her future husband. The inaccessibility of the patient and the fact that she not only thought hair was growing but that she actually saw it and feared that others observed it when it was not there spoke for a delusional rather than an obsessive thought. The husband's past and subsequent behavior only aggravated matters. For a time she behaved like a schizoid psychotic, but she recovered considerably and thus far has remained comparatively free from the obsession.

CASE 26. Compulsion; morbid scrupulosity. McDougall (1), p. 319.

An officer, X, in early middle life, of high culture and character, was troubled so much by morbid scrupulosity in the performance of his duties, which were mainly office duties, that he was sent to hospital. He suffered no other disabilities beyond occasional severe headache and an hallucination which he was loath to reveal, but which was the key to the trouble. He had been educated in a Jesuit college, and no doubt the practice of moral self-inspection there acquired may have in some degree prepared the way for the obsession. It appeared that, after training as a temporary officer, his first duty was to conduct a draft to a distant scene of war. The transport, crowded with troops, received two torpedoes from an enemy submarine, and went down amidst a wild scene of blood and agony and death, on a vast and concentrated scale. As the ship sank, most of those who remained alive sprang overboard. X remained on deck till the last. Shortly before the ship sank, a young officer with whom X was acquainted stood by him, wearing a life-belt. Presently this officer sprang into the water, and then, in frantic excitement, called to X to throw him his (X's) life-belt. Seeing that the other man had on his own belt, X refused to do this, and shortly afterwards saved himself by swimming to a boat, which he shared with a raving madman until picked up. The hallucination from which X suffered was a vision of the corpse of the young officer whose unreasonable demand for his own life-belt X had refused. X, being one of the very few survivors, had written an official report of the disaster and had carried on for a time; but he had never mentioned the intimate personal incident; he could not bear to speak or think of it; it was repressed. Hence the hallucination, and hence the morbid scrupulosity and self-depreciation which extended to all duties and obligations, however trivial. The trouble cleared up as soon as X was led to revaluate the incident by facing it and examining it rationally.

CASE 27. Compulsion; homicidal impulse. Wechsler (5), p. 171.

W. L., a married woman, twenty-six years of age, complained that thoughts of her own childhood kept recurring to her mind, that she had the desire to hurt herself especially when she heard that some accident befell another person, and that she was afraid she would become insane. But what distressed her most was the compulsive thought to kill her boy of two and one-half years. She always hid cutting instruments, feared to be alone with the child and often kept away from home to prevent the possibility of hurting him. The first obsessive thoughts had been directed toward herself, but later to her child and finally she felt that if she killed him she would be relieved.

The history is that she was a poor, self-educated, working girl who craved the better things of life which were beyond her reach. She was artistically inclined, loved music, the theatre and intellectual company. To escape the drudgery of work she married without love a simple, matter-of-fact, but very good and honest workingman, only to find immediately after marriage that she had made

a mistake in choosing a partner whose character was the very opposite of her own. She had been a "passionate" girl whose sex phantasies were shattered by contact with real love. The sexual act disgusted her to such an extent that she felt like vomiting every time she had intercourse, and she began to hate her husband who was all the time kind, devoted and innocent of her thoughts. Meanwhile she became pregnant and she had an abortion induced. The second conception resulted in the birth of the unwelcome boy. As time went on she began to hate the husband because he was the father of her baby, since if she had no child she would be free from the man who was the cause of her misery. She knew she was unjust to him, that he deserved better of her, but she could not help herself. To make matters worse the boy looked the image of the father and was very much attached to him. As she slowly and resistingly unfolded her story in response to questions the thought began to dawn on her that the dreaded compulsion to kill her child actually represented an inner wish to be rid of him who more than anybody stood in the way of what she conceived to be freedom. The mere bringing to the surface of the superficial psychologic mechanism involved served to weaken her compulsion. Although no complete analysis was attempted subsequent conversations led to tolerable readjustment with her husband and to freedom from the obsession.

CASE 28. Compulsion; homicidal impulse. Bluemel (9), p. 42.

An intelligent negro, a man of university education, complained of an impulse to kill his wife and boy. The impulse was more frequently directed to the boy, a child of ten. The boy's presence made him creepy and he felt an impulse to choke him. When chopping wood in the furnace room he felt an impulse to go upstairs and kill his wife and boy with the ax. At times he felt an impulse to do violence to other people, and he wanted to shoot or cut or strangle. When at home he would put knives out of the way and he took the ax away from the little boy when he saw him playing with it. Upon one occasion, when his wife was away from home, he had the boy stay with his aunt because he was afraid to have him in the house. When the boy came over to spend a night with him, he had him sleep upstairs while he himself remained downstairs in order to be away from the child. He insisted that he had welcomed the boy at birth and that he had a natural affection for him. His impulse to harm him occasioned the greatest distress.

CASE 29. Amnesia. McDougall (1), p. 248.

Sergeant B. was a man of excellent character and very fair education and intelligence. While on service in France he learned that his wife was guilty of an infidelity of a peculiarly reprehensible kind. He obtained leave, came home, investigated the facts, and put in hand proceedings for divorce; and, while on leave, considering himself virtually a free man, he renewed an attachment which had been broken off through misunderstanding some time before his marriage. This marriage he had contracted in a mood of reckless and quixotic generosity, but of very little affection, in the period of reaction following upon this estrangement.

Some months after returning to duty at the front he suffered "shell-shock." During a disastrous bombardment of his unit a shell exploded close to him. He did not wholly lose consciousness, but was obviously disordered in conduct and strange in speech. He was shortly sent home, and came under my care a few hours after landing in England. He was to all appearances a normal man, except that he could tell me nothing of his life and experiences between a moment some months before the outbreak of war, when he had a slight fall, and his setting foot

on the quay as he landed from the hospital ship a few hours before. He expressed himself entirely ignorant of the war, and was astonished at finding himself in khaki. But of all his life previous to the amnesic period he conversed frankly and intelligently. The complicated course of his domestic relations and the history of his military service were gradually revealed to him by letters and personal interviews with friends and relatives. He renewed his affectionate relations with the young lady to whom he had been at one time engaged, and, when informed of the renewal of their engagement, he accepted it. When informed of the death of his younger brother at the front during the early months of the war, a brother to whom he was much attached, he was overcome with grief.* He was keenly desirous of divorce and of marriage with his first and only love, his only scruple arising from the existence of his stepchild, for whom he retained a strong affection. The one barrier to his divorce was his complete amnesia for all the incidents on which his application must be based. If he could have overcome this, his way would have lain plain before him. He was conscious of no aversion from further service; for he had long been a keen volunteer and territorial soldier, and he had no conscious recollection of the horrors of the battle-field.

Every device was used to restore his memory, including visits to his home and to scenery he had known during his training for active service, and the reading of detailed letters from the front which he had sent home before his "shell-shock." But nothing availed. His case was explained to him at great length, and he took a very intelligent interest in it. He passed readily into deep hypnosis, and in that condition related many details of his life which in the waking state he seemed to have forgotten; but, with the exception of a few vivid pictures of his surroundings on the hospital ship which brought him to England, nothing of the amnesic period could be recovered. Always, and many times, when in hypnosis I pushed him hard, insisting upon his recollection, my hold upon him was suddenly resolved at the moment when the critical point of his narrative was reached, the hypnosis terminated, and he woke to normal consciousness and independence. This last feature of the case, which was very striking, is not very uncommon. It indicates unmistakably that the amnesia depended not upon a mere dissociation, but upon a continued and ever-watchful activity of repression, a repressing activity strong enough to defy the ascendency which I had acquired in the hypnotic state, as well as the strong desire of the patient to overcome it in order to be fit for divorce and remarriage, and to feel himself again in normal health. For, in addition to the amnesia, he suffered from severe headaches and a lassitude which contrasted strongly with his former independent and self-reliant character. Here, then, was a case in which all conscious motives, the strength and reality of which can hardly be doubted, prompted in vain the effort to recollect. The repressing forces prevailed over them and over every artifice by which I sought to evade or overcome them.

The subsequent course of the case threw further light on the repressing factors. After the failure of my prolonged efforts to overcome the amnesia, B. returned to civil life and his old occupation; and, as the amnesia continued, he was unable to secure the divorce he so strongly desired. About one year after his discharge from the army, he came to see me. There was then evidence that the repression was less complete. During his stay in hospital he had had no dreams, or could remember none. Latterly he had begun to be troubled by battle-dreams; and on several occasions he had suddenly passed into a trance-like condition of short duration. He had recently seen his former colonel, who

*It was though the fact of his brother's death had remained unknown to him. Yet he had known it and sorrowed over it a year before.

was also his present and former employer, to whom he was confidential clerk. This had brought no recollection of his military life to consciousness, but it may have made some stir in the depths among the dissociated memories. I judged from these indications that suggestion might now be successful. I plunged him into deep hypnosis, and at once he re-enacted the final scene on the battle-field. The dissociation was completely overcome; in the waking state he continued to recollect at will and recite the various events of the period affected by the amnesia. The main repressing force may have been a subconscious aversion from military service; and this may have been weakened by a year's security in civil life. I am disposed to believe that this was of secondary importance; and that the weakening of the repression was due to the lapse of time which had weakened the force of the painful emotions connected with the domestic tangle.

CASE 30. Automatism; fugue. McDougall (1), p. 258.

A colour-sergeant of long service was carrying a despatch from one part of the front to another, riding a motor-bicycle. He suddenly found himself, a few hours later, pushing his bicycle through the streets of a seaport town some hundred miles from the front. He was utterly bewildered and, in order to avoid suspicion of desertion, he surrendered himself to the military police. He remained unable to give any account of his long journey from a spot near the front to the seaport.* After some stay in various hospitals he came under my care. He had no symptoms beyond his amnesia for this short period of some hours' duration, and a certain depression and lack of self-confidence, such as naturally resulted from the circumstances in a man of his good record and responsible position. Waking conversation having failed to overcome the amnesia, I tried hypnosis and at once the amnesia yielded; the dissociative barrier was overcome, and he continued in the waking state to be able to recollect and describe the whole incident: how a shell exploded near him, throwing him down; how he remounted his cycle and set off for the seaport; how he found his way by studying the sign-posts and asking questions, etc. It was clear that, though his actions had been conscious, intelligent, and purposive, yet his conscious activity was of a restricted kind; he seemed to have had no thought about the consequences of his action, but to have been driven on by the single strong impulse of fear, taking the form of a desire to get far away from the danger-zone.

CASE 31. Alternating personalities. McDougall (1), p. 483.

Mary Reynolds, the daughter of a prominent Baptist, is said to have been of good normal capacities; "though in no respect brilliant, she seems to have been naturally endowed with an uncommonly well-balanced organisation, physical, mental, and moral." She had, in short, displayed no peculiarities of a striking kind, but remained a somewhat commonplace, unadventurous girl, until, when eighteen years of age, "she became subject to occasional attacks of fits." In the following year she one day took a book to read in a meadow and was found there insensible. On recovering consciousness she was found to be blind and deaf. Hearing returned suddenly and perfectly after some five weeks; sight more gradually but completely. These facts suffice to show that she was an hysterical subject, one liable to dissociative accidents. Three months after this episode, when she seemed to have nearly recovered her usual health, she continued one morning

*Similar cases were common enough during the war; and it is highly probable that a certain number were punished with the extreme penalty.

to lie abed in a profound sleep from which she could not be roused. She wakened spontaneously after some hours and then, "as far as all acquired knowledge was concerned, her condition was precisely that of a new-born infant," except that she pronounced a few words. But "she differed from an infant in this, that her faculty of acquiring knowledge was that of a person in the possession of mature intellect, fully capable of dealing at once with the facts of existence. She therefore rapidly acquired a knowledge of the world." After five weeks in this condition, she woke again in her former state, knowing nothing of her life in the intervening five weeks. After a few weeks she again, after an unusually profound and prolonged sleep, woke in the second state and took up her second life and processes of learning from the point at which the second state had disappeared. She continued for many years to alternate between these two states; in each state she was amnesic for the events of the other state, but had normally good memory for the events of previous periods of the same state; that is to say, there was reciprocal amnesia as between the alternating states.

If the two states had differed only in respect of their memories, it might seem inappropriate to describe the case as one of alternating personalities. But there was another great difference between them: namely, a difference of character and tastes. In the primary state Mary was, as we have seen, a somewhat commonplace person. In the secondary state she was extremely adventurous; she would take long rides alone through the forests, and was in many ways more lively and enterprising. The second state gradually increased in duration relatively to the first; and, towards the later part of a moderately long life, the primary state remained latent or absent. In this late period she sometimes seemed to have dim dream-like memories of her life in the primary state. And once, when in this second state, she dreamed of a sister who had died before the second state appeared; the sister so dreamed of was identified by her relatives from her description.*

*Passages of special theoretical interest are underlined.

II. EMOTIONAL AND AFFECTIVE REACTION TYPES

CASE 32. Manic reaction in girl. Kasanin (11), p. 101.*

R. L., female, white, age fifteen, school girl, admitted to the Boston Psychopathic Hospital July 18, 1929. Discharged to family against medical advice July 27, 1929. Diagnosis: Manic depressive, manic.

Chief complaint. After a fright several months ago, the patient became excited, sleepless, and restless. She expressed vague delusions of reference.

Family history. Nothing is known about the patient's grandparents. The parents are Russian Jews and are apparently stable people. The family consists of father, mother, and seven children. The patient is the youngest child.

Personal history. The patient was always a healthy infant and child. She played well with other children, was a good mixer, and had many friends.

The patient began school at six and made good progress. She was a B pupil. She had to stop school with the onset of the recent difficulty. Menstruation began at thirteen and showed no abnormality. She had the usual children's diseases with good recovery.

Present illness. The patient had never gone from home without being accompanied by some member of the family or by a friend. One evening in July, 1928, she went to a show alone because her chum (another girl) could not go with her. While at the show she became frightened by the man sitting next to her. She thought that he tried to put his arm around her or that he tried to punch her in the side. She ran home, cried, and appeared very much frightened, saying that some man had scared her at the theatre. She tried to describe him but she was very vague in her statements. She was extremely upset, restless, afraid, and cried for about two weeks. During this period she talked a great deal, jumped from subject to subject, laughed a great deal for no special reason, and tried to run out in the street in her nightgown. At times she wanted to be on the go all the time, at other times she preferred to stay in bed.

On the night of July 4, 1929, after taking part in the fireworks with the other children in the neighborhood, the patient went to bed about ten o'clock at night, apparently perfectly well. About midnight the parents were awakened by the patient who was sitting up in bed screaming and saying, "I know who touched me in the theatre." She had reference to the episode of a year ago, and proceeded to give a description of the man. From that night on the patient slept poorly, cried a good deal and was very unhappy. She said that she saw the Devil and thought that somebody was trying to kill her. She said several times, "I'll turn his key. God spare my life. I am sorry I went to the show alone." She talked continually for several days. One day she spoke about the Chinese and said, "I know the Chinamen have cut my heart out." At various times the patient spoke about poisoning and suicide. The family took the patient to a psychiatrist who referred the patient to this hospital.

On admission the patient was found to be in good physical condition. She was overweight, her height being 4 feet 11 inches and her weight 140 pounds. The secondary sex characteristics were well developed. Examination of urine showed rare hyaline casts. The blood Wassermann was negative. The white count was 12,200. The temperature on admission was 110.2° rectally, but it quickly dropped to normal.

In the ward she was very restless and overactive. She moved about a good deal, slapped her hands, and talked a great deal. Her motor activity was rapid and variable.

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In her speech she was overproductive. She talked spontaneously and was very anxious to discuss her affairs. At various times she said, "I worry and worry, and cry with tears." At another time she said, "I am a truthful girl, I am truthful Ruth, I am a virtuous girl." She pointed to the ceiling and said, "See the bright star, the bright shining angel star" (referring to herself). In the continuous baths she was singing a great deal, chanting some hymns or singing her thoughts.

Her mood was one of restlessness, agitation, fear, and unhappiness which alternated with periods when she was euphoric and elated.

She spoke a great deal about the incident in the theatre of a year ago. She constantly referred to herself as an innocent girl and said that if she saw the man again she would drop dead. When she was asked about the intentions of the man who had punched her in the theatre, she began to speak a great deal about her innocence. Outside of this there was no indication of any odd ideas. There was no evidence of any hallucinations. She seemed to be fairly well oriented although she took very little interest in her surroundings. Her intellectual functions were essentially unimpaired.

The diagnosis in the hospital was manic depressive, manic. She was discharged to her family after she was in the hospital nine days.

After the patient left the hospital she returned to school but found the work too difficult for her. After two months' trial she left school. Since the patient left the hospital she has had no more attacks. At times, however, after some altercation with a member of the family, the patient still becomes very much excited, screams and "carries on." She becomes so upset that it is necessary for her to go to bed. The patient utilizes her previous attack in order to dominate the family, and tells them that they have no right to cross her because she is a very nervous person. She is very well, physically, although she states that her health has not been so good as before her admission to the hospital.

The patient has attempted to analyze her illness and told the social worker that her upset was caused by a novel experience for which she was unprepared. As a matter of fact, she is not sure even now whether the man who approached her in the theatre actually tried to assault her or pushed her accidentally. She is very certain that her reactions now would be altogether different in a similar situation.

The patient's social life is quite normal and she enjoys an average amount of social contacts. The patient has very few misgivings about having been in the hospital, and feels that this was a very valuable experience as it gave her some insight into her difficulties.

CASE 33. Hypomania. Kraepelin (10), p. 59.

The powerfully-built and well-nourished merchant, aged fifty, who is brought before you today, enters the room with a rapid step, and greets us in a loud voice; he takes a seat with a courteous bow, and looks about him expectantly and with curiosity. He answers quickly and with assurance as soon as we address him, and gives fluent and pertinent information as to his personal circumstances, as well as concerning his present position. Very soon he not only answers, but also leads the conversation; says jokingly that he is not going to relate everything so glibly, but will make the examination a little more difficult, in order that he may see whether we understand anything ourselves. He explains that he suffers from paralysis, makes quite senseless statements, and adds up incorrectly, but is as happy as a king if you go further into things. If you give him free scope, he talks a great deal and with animation, hardly allowing himself to be interrupted;

but he easily loses the thread, forever bringing into his history some new irrelevant details. A short, concise answer cannot be obtained from him; he has always something to add and to exaggerate. During my lecture he, at intervals, frequently asks for "a hearing," but always draws back with a polite bow. He often addresses his discourse to you students, adverts to student life, interpolates verses from student songs, even making up some topical doggerel rhymes himself.

His frame of mind is joyous and exalted; he amuses himself with all sorts of jokes, even tolerably risky ones, makes fun of himself and of others, imitates well-known characters, laughs at his own tricks, which he knows how to put in quite a harmless light. For instance, the last few nights before his admission to the hospital he had gadded about to all sorts of taverns and disreputable houses, had drunk hard everywhere, behaved in the highest degree extravagantly, sprinkled himself from head to foot with water in the market-place, and had driven in a cab from one public-house to another in the neighbouring villages. Finally he smashed the mirror, crockery, and furniture in his own house, so that he had to be brought to the hospital under a strong escort of police. For all that, he observes cutely his wife alone is to blame, for she did not treat him properly, nor had she cooked anything decently for him. As a consequence, he had to go to the public-house, and, besides, he must give people something by which to earn a living. He does not consider himself to be ill, but, he adds with a significant smile, if it will give us pleasure, he will remain with us awhile. The patient does not present any physical disturbance, except some wounds that he sustained in being conveyed by force to the hospital.

This appears to us in every respect to be the exact opposite to certain states of depression that we have already learnt to recognise. Comprehension occurs quickly, ideas spring up unhindered, though soon driven out by something new. The spirits are cheerful, actions run untrammelled and without obstacles, without even those which act as a restraint in normal life. This combination of symptoms of disease, which we frequently meet with in the same form, we designate by the name of Mania, or, if the individual disturbances are only slightly developed, as in the present case, by that of Hypomania. Our patient is, however, by no means always so considerate and jovially amiable as he is at present. For a time, especially at the beginning, he was quite confused and incoherent in his headlong talk, very irritated by his surroundings, smashed tables, chairs, and window-panes, poured his soup over his head, and behaved in very disgusting ways. At other times, by teasing and ill-treating the other patients, slandering the attendants, and grumbling and making mischief at every opportunity, he was almost unbearable.

Mania, to a certain degree, is not only a true subversion of states of circular depression, but in itself is nothing but a stage of maniacal-depressive insanity. Where we really meet with maniacal excitements we are then able to draw the probable inference, not only that the excitements will recur often during life, but that states of depression of the kind already described will alternate with them. To return to our patient, we can state that he has already been in the asylum seven times. He is illegitimate; his mother died of an apoplectic fit; a sister of hers was insane. The patient had always been considered eccentric, but was sober and industrious. The first attack of the malady occurred in his thirty-seventh year, and exactly resembled the present one. At that time the patient, through the press, suddenly invited the whole "nobility of the place" to a "haute volée soirée" at a belvedere, drove up to the police-station with the pretext that he had discovered a long-wanted anarchist criminal in the person of a gendarme, and indulged in all manner of practical jokes with the officials. He was at that time supposed to be suffering from general paralysis. The later attacks began

with an inclination, for the time being, to extravagant expenditure, alcoholic and sexual excess, as well as every imaginable open misdemeanour; once on admission to the hospital he had all his pockets full of worthless rings, foreign coins, and cheap jewelry, which he had bought up everywhere, as well as numerous pawn-tickets.

At the beginning the attacks lasted from two to three months, and later on about six months. The patient generally soon became composed in the hospital, and scarcely presented even slight disturbances, yet a number of experiments of dismissal turned out badly because he at once began to drink again, and then quickly became re-excited. After recovery, he was, in the intervals, a very sober man, leading an extremely retired life, and on good terms with his wife, whom he tormented and insulted in his excitement. For three months after the last dismissal but one, and for nine months after the last, he was deeply depressed, misanthropic, lay in bed a great deal, and expressed thoughts of suicide, until his mental equilibrium gradually became restored.

The expectation already expressed by us has been verified. Not only have a series of maniacal attacks occurred, but in the course of the year attacks of depression with distinctive features have also made their appearance. Most probably the future will bring a more or less regular return of one or the other of these states.* That in the course of time the duration and severity of the attacks have increased, while the intervals have become shorter and shorter, corresponds with the general experience of the disease. The future course will probably involve a gradual aggravation of the behaviour of the attacks, with fluctuations possibly.

CASE 34. Acute mania. Kraepelin (10), p. 62.

As you may already have guessed from the noise outside, the second patient, who now storms into the room, is violently excited. She does not sit down, but walks about quickly, examines briefly what she sees, interferes unceremoniously with the students, and tries to be familiar with them. No sooner is she induced to sit down than she quickly springs up again, flings away her shoes, unties her apron, and begins to sing and dance. The next minute she stops, claps her hands, goes to the blackboard, seizes the chalk, and begins to write her name, but ends with a gigantic flourish which in an instant covers the whole board. She wipes it off perfunctorily with the sponge, again hastily writes some letters of the alphabet, suddenly flings away the chalk over the heads of the audience, seizes the chair, swings it in a circle, and sits down on it with vigour, only to spring up again immediately and repeat her pranks in other forms. During the whole time the patient chatters almost incessantly, though the purport of her rapid headlong talk is scarcely intelligible and quite disconnected. On addressing her impressively, one generally obtains a short, sensible answer, to which all kinds of disconnected sentences are, however, immediately joined. Still, one can sometimes follow up her erratic thoughts; they seem to be recollections springing up, fragments of phrases and verses, words and terms that she has heard formerly from her companions, and which she now interlaces into her stream of talk. The patient gives her age and her name, and

*After the setting in of tranquillity the patient was at first low-spirited for a long time, and a year later he again became maniacal. This time severe epileptiform attacks set in, with subsequent appearances of loss of power, in one of which the patient succumbed. The post-mortem showed widespread arterio-sclerosis of the bloodvessels of the brain. This termination appears to be not altogether unusual in maniacal-depressive insanity.

knows that she is in a "mad-house," but gives quite arbitrary names to other people. She refuses to be led into a connected conversation, but at once digresses, jumps up, addresses one of the students, runs to the window, sings part of a song, and dances about. Her mood is extremely merry; she laughs and titters continuously between her talk, but easily becomes angry on slight provocation, and then breaks out into a torrent of the nastiest abuse, only to become tranquil a minute after with a happy laugh. In spite of her great restlessness, she is tolerably easy to manage, and obeys orders given in a friendly tone, although it must be admitted that she immediately does something else quite different. There is nothing to notice in the physical condition of the delicately-built patient, except a certain amount of anaemia, and an inflammation of the margin of the left eyelid, which she will not allow to be touched.

The extraordinary mutability of the individual psychical processes constitutes the characteristic feature of the condition under consideration. These processes are quickly and easily induced, but just as easily supplanted by others. Some accidental attraction at once arrests the attention, but only for the moment; every arising idea or mood, every impulse of the will, is already replaced by another before it is properly carried out. Evidently the patient is wanting in ability to prevent herself from being ruled in thought, mood, and action by the changing influences of the moment, or to work these out to their proper endings. It is in this way that the important symptom of divertibility arises—that is to say, increased liability to influence through outward and inward attractions. In the province of comprehension it makes itself perceptible in that it is not impressions of real importance that arrest the attention, but those which, presenting themselves directly, are chosen at haphazard, to be at once replaced, just as accidentally, by others. Thus, in the province of the course of ideas, there arises that phenomenon which we are accustomed to call the "flight of ideas." As the idea of a goal is wanting which gives its fixed direction to healthy thought and at once arrests all side issues, the train of thought is perpetually driven out of its course, while incidental and non-essential ideas, often only awakened through habit of speech or similarity of sound, intrude everywhere. That the succession of thought is not hastened by this, as is generally taken for granted, but that the generation of new ideas often goes on very inadequately and slowly, can easily be proved by suitable experiments. But the designation "flight of ideas" is so far quite appropriate, as, in point of fact, the duration of the individual idea appears to be very much shortened; the ideas are "fleeting," and soon fade again before they have actually attained clearness. Hence, as a rule, there exists at the height of such disturbance a more or less pronounced incomplete consciousness.

The divertibility can be recognised in the abrupt change of colouring of the frame of mind, which can change in a moment from exuberant merriment to angry irritation, as well as to tearful despair. Lastly, in the form taken by expressions of the will, the disturbance shows as motor unrest, as press of occupation. There constantly spring up in the patient the most manifold impulses of the will, whose transposition into action is impeded by no checks, but is very soon crossed by new impulses.

CASE 35. Depressed and apprehensive boy. Kasanin (11), p. 104.

A. R., male, age twelve, school boy, white, admitted to the Boston Psychopathic Hospital, February 2, 1926. Discharged February 9, 1926, to a State Hospital. Diagnosis: Manic depressive, depressed.

Chief complaint. The patient was sent to this hospital because for some time he had been depressed and apprehensive.

Family history. The patient's grandparents were French-Canadian farmers, and were healthy, sturdy people. A paternal aunt suffered a psychosis following the birth of a child. Patient's father was an artisan, and came to America at the age of twelve. From 1910 to 1917 he was in several state hospitals in Massachusetts where his condition was diagnosed as dementia praecox.

The patient's mother was treated in 1916 in the out-patient department of the Boston Psychopathic Hospital. At that time her diagnosis was psychoneurosis with a question of early general paresis. The patient's father is said to have died in 1919 when the patient was six years of age.

The patient is the third of four children. The older brother was treated for neurotic symptoms in an out-patient department of the Cambridge Hospital.

Personal history. During the pregnancy the mother was quite depressed and run-down. The patient was born February 15, 1913. Birth and early developmental history were normal. When he was two years old he was at the Children's Hospital because of infectious diarrhea. The blood Wassermann test was positive and he was referred to the Psychopathic Hospital for treatment. He was treated in the out-patient department with arsphenamine. His blood Wassermann tests were at times positive, at other times doubtful or negative. The patient was treated in the syphilis clinic at various periods until 1922.

As a child he played normally with other children and was a very friendly youngster. He loved outdoor sports and played very actively. He played with boys who were smaller than he. He also liked to play with his toys in the house.

In school his progress was not very satisfactory. He had no ambition and did not care to do his work. He stood fairly well in his studies although he had some difficulty with arithmetic.

The patient masturbated until the age of six, then his mother told him that it was bad for his soul, bad for his body, and a mortal sin. He gradually stopped the habit. Between the ages of five and seven there had been some sex play with a little girl.

He was quite sensitive. He had a level temperament, was sociable, made friends easily, was energetic and lively. He was not a day dreamer but was fond of reading fairy tales. He was adaptable and got along well with other children and with his teachers. He liked to make things with his hands. The mother was very religious and the patient also seemed to be very religious and went to mass every morning. There has always been a great deal of pressure to see that the patient should go to church frequently.

Since early childhood the patient had been in constant dread of his father who at times came home and threatened their lives. The patient and the other children in the family were constantly afraid that the father might escape from the hospital. A year before admission the patient was boarded out by the family for economic reasons. The patient was always extremely devoted to his mother.

Present illness. In September, 1925, the patient entered the House of the Angel Guardian. He bore the separation from his mother and the family with great difficulty. He was dissatisfied and lonesome. In January, 1926, he was unusually quiet and complained to his mother that he was always being watched and that the boys were teasing him. This was probably untrue. On January 30, 1925, the patient went to confession, but on the following day he cried and asked permission to go to confession again. The same thing happened on the following day. The confessions did not quiet him, he was crying and afraid. He had pilfered some grapes and candy and, apparently, it worried him a great deal. When he was before the priest he was bashful and could not say anything. On

February 1, 1925, he was brought home and put to bed. He seemed tired, slept for a while, and appeared to be thinking. He called his mother, told her that he was afraid, and that he was not pleasing God because he was stealing things. On February 2, he did not want to get up. When his mother decided to take him to the hospital he acted as if he were drunk. He dropped his head between his shoulders, leaned against his mother and complained of sickness. He walked slowly, dragged his feet and was very frightened.

On admission to the hospital the boy was found to be in good physical condition. A thorough neurological examination was impossible on account of lack of cooperation. An examination of urine, blood, and spinal fluid was negative.

In the ward, he was anxious and depressed. His eyes were filled with tears, yet he refused to answer any questions. He was preoccupied and at times almost stuporous. When the topic of taking the candy was discussed, he showed signs of deep emotion. It was impossible to say definitely whether he had or had not odd ideas or false sensory impressions. He cooperated very poorly in the examination of intellectual functions. The patient stayed in the hospital seven days, and a few days after his admission he became more cheerful and began to take some interest in some of the ward activities.

On February 9, 1926, the patient was committed to the Westborough State Hospital. He was quite weak and complained of a severe headache which followed the lumbar puncture at the Psychopathic Hospital. He was quite indifferent at first, but after a while he became more cooperative with his physicians. The hospital record states that the patient had auditory hallucinations on admission, but these gradually disappeared and the patient admitted that they were his imagination. The patient got along so well in the hospital that six weeks later, on March 29, 1926, he was discharged to his family.

The family sent the patient to some relatives in Canada for a short visit. In the fall of 1926 he was sent to an orphanage school in Lowell because there were no facilities to take care of the boy at home. He was taken back home in the spring of 1927, and placed again in public school. He did well in school but at home he was frequently dreamy, seclusive, and disobedient. The mother was very strict with him and would not allow him to go out with other boys. During the summer of 1928, the mother put him to work as an errand boy. He was disinterested in his work and used to skip off to the movies quite frequently. For this reason he lost several jobs. He continued with school in the fall of 1928. At home he was very stubborn, disobedient and kept away from the rest of the family. In the winter of 1928-1929, the boy became very much interested in sex. He began to peek into the apartments of neighbors, watched girls dress, etc. He was quite an enigma to his family and never told them anything about his interests or aspirations. He did not even speak about the movies which he frequented a great deal. In April, 1929, the boy stole an automobile, and because he had been a patient before at the Psychopathic Hospital, the court sent him to the Psychopathic Hospital for examination.

The examination at the hospital showed a tall, lanky, well developed young boy in excellent touch with his environment. His mood was quite appropriate and he showed no evidence of any odd ideas or hallucinations. He was discharged back to the court, placed on probation, and since that time he has been working out of town, apparently getting along quite well.

It is interesting that while at the Psychopathic Hospital the diagnosis on first admission was manic depressive, depressed, and the diagnosis at the State Hospital was dementia praecox, hebephrenic. The latter diagnosis was made on account of the hallucinatory experiences of the patient. In a case like this it is extremely difficult to unravel all the components which may have contributed

to the patient's illness—poor heredity, congenital lues, extremely narrow religious upbringing, a rather special personality, and, finally, extremely serious environmental stresses.

CASE 36. Mild depression, diagnosed early. Dorcus and Shaffer (12), p. 318.*

J. R., aged 21, male, single, student.

Family history. Two of the patient's maternal uncles committed suicide and his father made two unsuccessful attempts during a depression.

Personal history. The patient was described as a quiet, shy young man who three years ago had gone through a four-week period of depression following a recovery from influenza. He is said to have done fairly well at school but had had to study particularly hard. His father and one uncle were successful physicians and he had his heart set on finishing medicine. At the time of his second breakdown he was in the third year of college and was experiencing great difficulty in the science courses. He returned home from the physics laboratory one evening and went immediately to his room and drank a large quantity of iodine. He was rushed to a general hospital for treatment, was so morose and dejected that he was transferred to the mental hospital. When he was admitted he was in a dull, depressed state, feeling hopeless and much concerned that he had not been learning as he should. It was difficult to get him to talk or answer questions and if he responded at all it was usually in monosyllables. He stated that he was melancholy, that his mind was occupied with morbid things and that he would be better off dead. His general physical condition was good and his intellectual faculties were not impaired. There was very little response to things about him and he refused to participate in any activity. For the most part he sat in the ward rubbing his head and eyes, beating his fist on the chair and occasionally moaning, "My God, please let me die." He said that he was not as efficient as others, that he could not hold his own and would never be successful. There was much talk about being a burden on others and there was one attempt at suicide within the hospital.

After about three weeks in the hospital the patient gradually began to discuss his problems more easily. It was learned that he had never wanted to study medicine, always had found science difficult, but was attempting to satisfy his father who wanted him to be a physician. He had never done well in science and had begun to believe himself inferior and doomed to failure. An attempt had been made to secure approval in athletics, but he had recently been dropped from the school basketball team. A thorough study of the patient's intellectual and personality traits was attempted and it was discovered that he was above average intelligence, had an unusual facility in language, was a fair tennis player and was greatly interested in finance. Through careful supervision of his activities and discussion of his problems he gradually became more interested in his environment. After four months stay in the hospital he was discharged with good insight into his problems and definite plans for the future.

He has since graduated in law with honors, won the third place on the tennis team of the school and appears to be very well adjusted. A good bit of his leisure time is spent in modeling, an activity which he began at the hospital.

CASE 37. Involutional melancholia. Dorcus and Shaffer (12), 321.

F. F., female, aged 50, married, Jewish.

Main facts. The patient is a tense, meticulous person who has been treated for fifteen years for indigestion. At the menopause she became worried and censured herself about the acquirement of property which was later disposed of

*This and cases 37, 38, 42, 45, and 46 reprinted by permission from Textbook of Abnormal Psychology by R. M. Dorcus and G. W. Shaffer, published by Williams and Wilkins.

at a sacrifice. She was restless, depressed, discontented and went from hospital to resort without improvement. She finally refused food, denied the existence of her family and thought she was "a stone."

Family history. While a number of the members of the family are neurotic no frank mental illness is admitted.

Personal history. The patient was born in Germany, and came to the United States at the age of 16. She had pleurisy, neuritis, and an ovariotomy and appendectomy. She had been treated for indigestion for 15 years. Puberty was established at fifteen and was irregular with dysmenorrhea. There was an artificial menopause with flushes following an ovarian operation. The patient was married to a traveling salesman at the age of seventeen and has two sons. She was active, tense, enjoyed cards and loved her home. She was rather moody with swings of elation and withdrawal from friends, rather than depression.

Two years ago she bought an apartment house and was somewhat elated over her purchase, but when her husband did not approve she became worried. She was emotional, anxious and began to have a feeling that it must be disposed of. This was finally done at a considerable loss. Several months later she complained of depression, anxiety, and felt that she must leave home. At a health resort there was some improvement but a mild accident accentuated her gastrointestinal symptoms. She could not sleep, was dreamy, had no interest and changed hotels in one city several times. Then she complained of being heavy, dazed and fearful of impending disaster. She became listless and indifferent, denied the existence of things and refused to accept her sisters as her family.

In the first month of her hospitalization she answered all questions with "yes" and "no," "I don't know—don't remember," and was preoccupied, depressed and tearful. Occasionally she would say, "I am too heavy. I can't read or move. I can't do anything. I am a stone." At other times she asked the nurse, "Are you me? I am not me. I don't know why—I am nothing. I weigh only ten pounds. I am little and dirty—it is just like a baby crying." In answer to questions she said she was "supposed" to have had a husband and "supposed" to have had a family. She thought that every one was against her and that she was the only one left and believed that all those about her were ghosts. She said she had no stomach, called the hospital a prison, misinterpreted the ward activities and denied the existence of everything. She continually talked about her unworthiness and remarked that everything was lost and she would never recover. Her movements indicated retardation and difficulty in execution of activity while her facial expression was one of distress, apprehensiveness and depression. She said she had been a liar and deserved to be punished, that she has had unpleasant thoughts about her family and has treated them badly. Later the feelings of unreality became accentuated and she refused to eat, saying she had no stomach and had turned to stone.

The patient gradually became more childish in behavior and was frequently crawled about on the floor, refused her food and cried, "Oh my—me so little—you so big." She became increasingly untidy in her habits and resistive to any care, refused to go to the toilet saying, "me don't have to go to the toilet—me don't have to have bowels moved." She had to be bathed, dressed and tube fed and became more and more resistive and abusive. She talked like a baby, muttered to herself and dribbled saliva like an infant.

The patient slowly but gradually improved and began to speak of learning to walk and talk and slowly developed an interest in adult things. Her interests and abilities in occupational and recreation classes were carefully watched and fostered and she began to show a more adult attitude. She was allowed to visit home periodically and slowly began to take over her duties at home. At the present time she has been out of the hospital for two years and is doing well.

III. SCHIZOPHRENIC REACTION TYPES

CASE 38. Schizophrenia; simple type. Dorcus and Shaffer (12), p. 281.

J. S., male, single, aged 28, high school education; Protestant, no occupation.

Main facts. The patient had a fairly normal and uneventful childhood. He seemed to progress with average success through grammar school, but did not finish high school after six years of effort, though he held many athletic, social and campus honors. His inadequacy in occupational adjustment became manifest, and he began to express ideas of reference and to hear voices. There has been considerable worry over masturbation and homosexual activity. His course has been steadily downhill.

Onset and symptoms of the present psychosis. After spending six years at high school, the patient enrolled for a special course in a university, but was sent home as unprepared. Shortly after this he showed his father a cartoon, depicting a young man who was wasting his life. The patient was convinced that the drawing was a reference made to him. Thereafter, he frequently expressed ideas of reference, often with sexual content. He tried various jobs, but was never able to adjust to them, and his whole disposition seemed to change. He became irritable, listless, disinterested in everything, and physically rundown. He spoke of his inferiority, unworthiness and guilt. Finally, he became actively suicidal and had to be taken to the hospital.

Course in the hospital. In the hospital he was friendly and talkative. His speech was incoherent and his thought processes were, on the whole, loosely connected. Emotionally, he seems quiet and contented, though occasionally he cries and says that he is not worthy of the good treatment which he receives. His mental content has apparently been largely occupied with ideas of reference for some time. He has had auditory hallucinations and feels that everyone knows of his sexual experiences and calls him vile names. There is considerable evidence of regression, his behvaior being for the most part typically childish. The patient enjoys talking about his childhood friends and the family's old cook who used to make cookies for him, but he changes the subject when his friends of later years are mentioned. On most occasions, he talks with a speech impediment which was present in his childhood. He has taken such interest in the athletic programme that when thoroughly engrossed in a game most of his childishness disappears, with excellent judgment and much initiative resulting. Together with the regression has come a lack of response to emotional stimuli and rambling talk that at times is impossible to follow. An idea of the confusion and diversity of topics he covers may be gained by the following list of general headings which he covered in the order given.

"I give you my word of honor that I am the same boy that came here. My word of honor is not worth a damn. (Here, he tells a very confused story of some trouble he was involved in once over an examination at school)—electric lights in my home—lighting candles—matches 'I am sure they only used one match a day'—smoking—'I used to smoke before I came here, but I don't any more. I don't think I should have given it up'—trip to Atlantic City—meals—shooting gallery—'I never shot a gun in my life'—cold water—Cathedral Street—(Here he debated whether or not Baltimore and Atlantic City were the same place and finally decided that they were not)—tells of buying a shirt—tells of seeing a certain picture in Atlantic City—'I have been separated from my father for four years now'—tells of someone giving him a piece of cake—worry about food! 'My father wrote me not to worry about food. What shall I do about that?'—says

he talked disrespectfully about food—played baseball—'I saw a man so near death that a breeze would give you a cold'—'I have nothing to complain of except an extra large stomach and a swelled head over it.' "

The emotional dilapidation may be clearly shown by citing another example. The patient had been described by the informants as being quite closely attached to his mother, and the following is an acoount of his reaction to her death. The patient's mother died while he was in the hospital, and he was called into the office and acquainted with the fact. He replied, "Is that so? That's too bad. She was a fine woman. Say, doctor, isn't there some way you can excuse me from going to the dining room? I am eating too much and getting too fat." He then began to talk about the baseball game he had just participated in and never once mentioned going home to his mother's funeral.

CASE 39. Schizophrenia, illustrating onset. Strecker and Willey (13), p. 409.*

Female, aged thirty-five years, single, born in Pennsylvania of American parents. The patient was the second of three children, and following the birth of the youngest the mother developed an acute mania (?) which merged into a chronic psychotic state, marked by paranoid ideas, chiefly against her husband, which persisted until her death at fifty-four of diabetes. Five maternal aunts and an uncle were artistic and "highstrung." The father had a tic.

All in all the patient's personality was a helpful one. She was vivacious, eager and friendly, energetic and thorough, optimistic and philosophical, and the principal handicaps were self-consciousness and a tendency to introspection. Her education was obtained in both public and private schools, being the equivalent of college preparation. The study of music began at six and was probably a constant source of pleasure and relaxation. She taught kindergarten, was very successful in her chosen work and "handled children well." At the age of nine she had an injury, the details of which are lacking, and was "upset and nervous" for a long time afterward but regained and maintained normal health.

The immediate precipitating circumstances had to do with overwork, gradually waning health and strength, and loss of weight, but they were the culmination of a long history of deterrent influences which reached back into early childhood. From her babyhood until the beginning thirties, the environment in which the patient lived was excellent culture material for the growth of mental abnormality. The mother was insane and the victim of many delusions, and there was constant friction in the household. She did not escape from these depressing surroundings until three years before the psychosis appeared and it is clear that the single year in New York where she taught kindergarten was perhaps the most satisfactory of her existence. "She was happy and contented and had many friends and recreations." However, the mother died and though a conflict between desire and sense of duty must have arisen, the patient promptly returned to her home where for three years she was "dissatisfied, unhappy and overworked." This was the opinion of her brother who saw beneath the surface. He said "she disliked housework, but did it cheerfully, repressing her feelings." During the psychosis, when inhibitions were lowered, the patient said, "Father and brother expect me to get strong and wait on them for the next thirty-five years."

The objective phenomena of the psychosis appeared abruptly. She became worried, talkative and erratic, and visited the neighbors with a bottle of medicine which the physician had ordered, asking their advice as to whether it would be safe to take it. She was flighty and had difficulty in completing sentences.

*This and cases 40, 44, and 47 reprinted by permission from Schizophrenia, published by Williams and Wilkins.

"A few days later she had a sudden excitement, was noisy and fearful, had visual hallucinations, saw imaginary faces at the windows. Now she has ideas of persecution and accuses her father of hypnotizing her. She mistakes the identity of persons and is often disoriented for time and place. She has crying spells."

The psychosis, which had a fourteen months' course, recalls her mother's mental disease by its division into acute and chronic phases. For several weeks there were acute manifestations: objectless overactivity, shrieking, grunting, hawking and expectorating to rid herself of the "black stuff" in her teeth, visual hallucinosis, a paranoid delusional trend—her father had "wished something on her," she had been made "crazy," there were "no friends," "only fiends," etc. There were episodes of posturing with closed eyes and mutism. These symptoms stood out from a background in which there was no discernible tract of affective accompaniment, and a diagnosis of catatonic schizophrenia was made.

Although the emotional component remained more or less formless, the delusional direction of the psychosis came more clearly into view. Her mind was being "read" by doctors and nurses, she was in the hospital for "research," felt "harnessed like a horse," someone was "using" her mentality. She referred to the "code of ethics of those who have me in charge" and "a consultation of the people in charge of me." Thoughts were thrust upon her mind, and she was pulled like a rubber exerciser; she was in the hospital for a purpose; there were wires under the floor; while she was talking, her mind was doing something else and she "could not control" her muscles and gestures. Auditory hallucinations both broke in on and repeated her thoughts. She frequently asserted that she was married and once declared that she was pregnant and hoped the child would be a boy. Her memory was good, orientation not more than partially lost, if at all, and the sensorium not obviously disordered. However, something had "dropped" in her head and it felt "muddled." While the signs of affective currents in the main were wanting, occasionally there was flippancy and weeping; once she buried her face in the bedclothes until cyanotic (presumably, from the setting, a suicidal attempt); and finally, as the mental symptoms began to give way, there was a suggestion of exhilaration. The improvement was gradual; the recovery was complete and has been held for three and one-half years.

CASE 40. Schizophrenia; illustrating affective reactions. Sullivan (24), p. 147.

Q. R., aged twenty-two, was admitted January 10, 1924, in the third year of his illness. He was the sixth of 6 children, 4 boys and 2 girls. Two of the brothers were army officers, the other an architect. His father died when he was three months old. One uncle suffered from epilepsy, another died of "paralysis." The younger of the sisters presented a psychopathic personality, was extremely selfish and of a vicious temper. His father was a clergyman, in a family with strong military traditions. His mother was decidedly "neurotic." She now wishes that he was dead.

His birth and very early development were reported as entirely normal. He had many severe illnesses early in life. The boy prepared for West Point, but was rejected because of physical disability, including defective vision. As a boy, he was of indomitable "will," earnest in his studies but not especially bright. He was disobedient with his mother, so that an aunt undertook his training. She seems to have been a severe disciplinarian, from whom after a year, he returned "like a whipped dog." She bewailed his tendency to lie, which she probably cultivated by unreasonable discipline. He was always silent as to his inner life, about which the informants could give nothing.

He underwent 3 operations for varicocele during his fourteenth year. While

he had been popular with boys and "got on nicely" with girls, he developed but transient love affairs of the heterosexual variety, and deep attachments for a few of his male companions.

He became frankly psychopathic during his sophomore year in the university to which he had gone, following the disappointment concerning West Point. He became "nervous, restless and depressed, was unable to study and could hardly write his compositions. After classes, he sat about his room with his roommate for whom he had a marked fondness. It is said that early in the incipient psychosis he obtained some grape juice and tried to make poison out of it, in order to make himself sick and obtain the sympathy of the roommate.

He went for a brief period of observation to the Walter Reed General Hospital, where his condition was diagnosed as dementia praecox, simple type, and then to a state hospital in June, 1923. On admission he is reported to have said, "I had a breakdown—I didn't take any interest in anything. I felt like I was nearly dead, then I got better; I went through several stages. Well, I got so I didn't like anything, then I got so I liked everything all right. People jump up or get red or something strange, and I knew something was the matter with me. I could see that they were all right a piece off and when they would come to me they would turn red. When I would be talking with people they would turn red and wonder why I couldn't find out what was the matter myself. They wondered why I couldn't experiment and find out what the trouble was, and I have already experimented. [What did you find out?] That these doctors were telling me I was High Yellow (hallucinated over a considerable period). They think I am too yellow to experiment; they either mean that or they mean when a man goes to have connection with a woman, he can't do it. Some men think I am a fairy." Subsequently he underwent a severe catatonic phase, in the course of which his mother removed him. The diagnosis was that of paranoidal dementia praecox.

He was readmitted to the Henry Phipps Psychiatric Institute where at first he improved to the point of writing to his mother, "I hope my imagination will clear up soon." Following an elopement while in the custody of his mother, he was returned to the Institute "restless, very antagonistic, and stated that there was a barrier between the physician and himself." His condition was described as a schizophrenic reaction type, with at first catatonic and later paranoid features.

After transference to the Sheppard and Enoch Pratt Hospital, he underwent a prolonged catatonic psychosis. His present condition is such as is commonly described as deteriorated. From the time of admission the affective side of his mental life has been observed and has never seemed to be beyond reach except during periods when his physical health was very low. Comprehensive observations, cinema reproductions of more recent behavior, and other physical data (which will be embodied in the forthcoming study) support the notion that neither cognitive nor affective features have dropped out of his mental life—this notwithstanding the long illness, many months of mutism, artificial feeding, untidiness, "silliness," "blankness of expression" (according to usual standards), disregard of flies walking on his face, alleged unobservance and indifference, and months in which his solitary daytime occupation has been public masturbation and expectoration.

CASE 41. Schizophrenia in soldier arrested as spy. Southard (8), p. 201.

A German private, called to the colors, was supposed to take his civilian clothes to the post office along with his comrades on March 21, 1915. He did not get his package ready in time and was ordered to go with another troop. At an

opportune moment, he left the barracks with the package of clothing. When later arrested, he said that he had gone by railroad to Dirschau; then he had visited Berlin. After this, he had walked to Bromberg, Schneidenmühl, and Landsberg.

At last he had ridden back to Küstrin. At Küstrin some children told a railway official that the man was making drawings. There was a petroleum tank near by. Accordingly, he was arrested as a possible spy. He claimed that he was not a soldier.

In the clinic, he looked dull and smiled a good deal. It seems that, before being called to the colors, he had been very angry with his wife and had even threatened her. He now explained this anger as his wife's fault. She had attacked him, he said. He said that he sometimes had attacks of weakness, which used to last two days at a time, but they had recently lasted for a shorter time. He said that his thoughts always wanted to be somewhere else. In fact, he had not performed military duty. His uniform had been gotten for him, but he had had no further orders. Sometimes in a fever or dream his head seemed to be as big as a room, as if there were no space for it. There was an itching in his legs, he said, which often fell asleep so he could not stand on them. He had had syphilis seven years before, after which he had been hoarse, forgetful, and anxious.

Examination showed perceptive power and knowledge to be good. He played the violin, but always the same tunes. He said that he had not worked in Berlin during the winter of 1914. He spoke as if he had been in another sanitarium, where he did nothing but dream by himself, taking no interest in things, and lying indifferently, with a blanket over him.

He said that when he received the uniform he had a longing for clean underclothes. Requested to explain the meaning of the uniform, he remarked: "Why, many have these things on."

Re dementia praecox, Lepine states that in the French army instances of dementia praecox have been numerous in the interior, both at the time of mobilization and at the time of calling out sundry new classes. He notes that the courtmartial and invaliding experts have neither the leisure nor the experience necessary to keep these men from going into the army. The somewhat frequent remissions in dementia praecox make the task all the more difficult. To be sure, the stuporous and catatonic cases are not very much in evidence in the army; when such cases do occur, it is easy enough to evacuate the patients to a hospital for observation. Far more troublesome are cases of a less advanced or milder nature. Here are cases in which judgment is deficient, and in which quite unsystematic, incoherent, and transient delusional ideas occur. The patient looks quite normal to the non-psychiatric expert. Something odd happens which quite suddenly reveals the delusional ideas. For example, there is a fugue, or else the soldier goes to his superior and aggressively chides him for having troubled him the night before. These particular psychopaths are among the most dangerous to be found in the army.

CASE 42. Catatonic episodes, with recovery. Dorcus and Shaffer (12), p. 293.

J. R. V., aged 30, male, married, Catholic, college graduate.

Main facts. The patient has been hospitalized four times in the last six years. The first of these episodes followed considerable worry on his part lest he inherit his mother's mental weakness.

Family history. The mother has been psychotic for several years and is now in a state hospital diagnosed paranoid schizophrenia. There is no other history of mental illnesses in the family.

Personal history. The patient is said to have been a normal, healthy,

agreeable child with no history of temper tantrums. His scholastic work was above the average and he was much interested and quite successful in athletics. There is some history of masturbation with much preoccupation regarding the possible result of these practices. From early childhood the patient attended school and social events with a young girl and the families have long felt that they would eventually marry. This event did materialize following the patient's second hospitalization.

In the fourth year of college the patient became greatly interested in medical books and one day asked his father, "Do you think I will inherit my mother's weakness? Do you believe insanity is hereditary?" A few days later he called a physician who is a close friend of the family and asked the same question. Despite the reassurance given him by both his father and his friend he continued to be much preoccupied with the possibility of inheriting his mother's weakness. He became elated, overactive and adopted a commanding attitude. Finally he ran from the house, clad in his pajamas, waving a crucifix and shouting "You do not believe in this. You are no good." When he came to the hospital he was much preoccupied with thoughts of insanity being hereditary, of his intentions to marry coupled with his fear of passing on his mother's disease. He was hallucinated, particularly in the olfactory field, and was for a time mute and did considerable posturing. The patient was discharged in apparently good condition, after five months' stay in the hospital. At this time he stated that he was aware of the fact that he had a number of peculiar ideas, that he was ill at ease in the company of others, his hands perspired profusely, he was emotionally unstable, and that he noticed that his pupils were widely dilated all of the time. He had had many notions about the loss of his sexual abilities, which he, however, referred to his irregularities.

He returned home, finished his school work, and took a position at which he was quite successful for a year and a half. At this time he told his father that he felt his old illness returning. He was preoccupied, fearful and anxious and was readmitted to the hospital. In the hospital, he held postures, felt that the doctors were talking to him in symbols, misidentified those around him, was hallucinated in the olfactory and auditory fields and was usually mute. He gradually became cooperative, was given parole and after about an eight month period was again discharged.

A few months later he was married, and six months after his marriage he visited the hospital to see the dedication of a new building. On this occasion he left his wife sitting in the car, entered the building and three hours later was found lying on a bed in one of the wards, mute. He was mute for two days, refused to eat and was preoccupied for about six weeks. He at times expressed ideas that his mind was being read. He gradually began to take interest in the activities and was discharged after a six months stay.

He spent the following year and a half in a leisurely manner with considerable success. He began to complain of feeling tired, of not sleeping well, and lost his appetite. He became preoccupied and finally maintained a fixed position for several minutes. The following day he became confused, indecisive and was brought to the hospital. For several weeks after admission the patient was mute, resisted feeding, assumed fixed positions for long periods of time and appeared confused and out of contact. He gradually came out of his stupor and was again discharged after six months hospitalization. At the time of his discharge he showed no deterioration or signs of having been mentally ill.

CASE 43. Catatonic stupor. Kraepelin (10), p. 33.

The next patient whom I will bring before you today is a merchant, aged twenty-six, who comes into the room under guidance, with closed eyes, hanging head, and shuffling gait, and at the earliest opportunity sinks limply into a chair. On being spoken to, his pale, expressionless features do not show any animation; the patient does not reply to questions or obey orders. If you stick a needle into his forehead or his nose, or touch the cornea, there follows at most a slight blinking or flushing, without any attempt at defence. But during this the patient quite unexpectedly breaks into a slight laugh. If you raise his arm in the air, it falls down as if palsied, and remains in the same position that it took accidentally. After much persuasion the patient at last opens his eyes; he now also gives his hand, advancing it by jerks with stiff angular movements, and remains like that. If you bend his head back, he stays in this uncomfortable position, and his leg, which I have raised up, he also keeps stiffly stretched in the air. By degrees one succeeds in calling forth still further signs of automatic obedience. The patient raises his arms if anyone does it in front of him, and imitates pushing and turning movements, whirling his fists with great exactness and rapidity. On the other hand, he does not utter a word, presses his lips together when he ought to show his tongue, cannot be induced to write, and apart from sudden, repeated grins, remains quite mute, but repeats some words shouted out loud to him with his mouth closed. He at once obeys the order to go.

The characteristic disturbance of will that forms a mixture of automatic obedience and negativism is, above all, obvious in this patient also. In a quite inexplicable manner the patient allows himself on the one hand to be influenced without will of his own, while, again, on the other hand, he suppresses the natural impulse of the will or that introduced from without. This contrast is best illustrated by his mimicry of speech with his mouth shut. As the result of his negativism, the patient has not for a long time opened his mouth in trying to speak, but yet he cannot quite withstand the impulse to imitate what is said before him. From this we recognise clearly that negativism and automatic obedience are psychological, but not clinical, contrasts. Indeed, both disturbances not only come forward in the same patients at the same time, but they also very easily change into one another, so that you are never quite sure whether at a given moment you will meet with the one or with the other in a given patient. Sometimes also, through various suggestive means, you can at once lead over the one into the other.

As it would appear, both are only an expression of the fact that the control of that deliberation, conscious of an end, over the impulse of the will is lost, so that now impulse and counter-impulse of inner or outer origin determine irregularly the subsequent action. Thus, at least to a certain extent, one would understand that the patients, even if their deliberation is not affected in itself, involuntarily first follow that impulse which presents itself to them, only persistently to answer it in the most stubborn way with the counter-impulse, or to repeat some senseless action or other innumerable times, in every case without any regard for their own weal or woe. It is clear that such a loss of connection between thoughts and actions, which perhaps rests on the profound destruction of the sensory life, must quite rob the action of that inner unity and logical accuracy which we regard as the issue of healthy mental personality. By this means, even in the slighter forms of dementia praecox, the proceedings and behaviour of the patients keep up their incomprehensibility and their confusing tendency to jump from one thing to another.

No one defined colouring of mood is to be observed in our patient. On the

contrary, he is completely dull emotionally, shows no interest in what goes on around him, not even on the visits of his nearest relations, in whom he shows no interest, and to whom he speaks not a word; he has no wishes, and does not care about anything. At the same time it can be seen from his occasional utterances that he is clear as to his situation, knows the people about him, and takes in what one says to him. Here again we find the same grouping of the disturbances in the order in which we were able to place them in the cases of dementia praecox already discussed.

This conception is also in accordance with the previous history of the patient. His father was temporarily insane, and could not on that account finish his college course. The patient himself learned with difficulty, after having struggled through typhus in his youth; was easily excited, anxious, and inclined to hypochondriacal broodings. He fell ill six months ago. As the result of differences of opinion as to plans of marriage, he became anxious, believed himself to be mocked by everyone, was afraid of coming into contact with the public prosecutor, and finally, because he looked upon his life as threatened, sprang out of the window one night in his shirt, fracturing his os calcis. On admittance, the patient was decidedly dull; he declared himself quite ready to remain in the hospital, although he was not insane, but only suffered from delusions. He had thought he would be murdered; everything appeared to him so changed; voices spoke to him about all sorts of family affairs; catalepsy, echolalia and echopraxis were very marked. There was no demonstration of physical disturbances except an old scar on the head and a newly-formed callus on the foot.

In the further course of the illness the patient's want of judgment, as well as his emotional dullness, became more and more marked. He thought that the meat placed before him to eat was human flesh; everything in the newspapers was about himself; the assassination of the Empress of Austria and the Peace Conference had to do with him; his mother wanted to murder him; he was the worst man alive. The doctor he designated as the German Emperor, who had dyed his beard; another gentleman as Christ—all in quite an indifferent tone of voice, without a trace of emotion. Sometimes he said senseless rhymes to himself—"Nem, bem, kem, dem, schem, rem"—over and over again, or he repeated this incomprehensible sentence: "One for all, and all for one, and two for all, and three for all, here and there everywhere, and 'Almightiness,' and 'Almightiness,' and 'Almightiness,'" and so on. Gradually he became more and more quiet, and gave up speaking and eating, hid himself under the bedclothes, took up extremely uncomfortable attitudes, and allowed the saliva to run out of his mouth; he has only latterly become rather more active again.

A whole series of disturbances recur here with which we are already familiar: the illusions, the strange hallucinations, the dullness, the refusal of food, the twaddling speech, with play on words and stereotyped repetition. Through other symptoms, such as the hiding, the strange attitudes, and the slobbering, which are likewise frequent in dementia praecox, the description of katatonic stupor becomes still more complete. As to the future course of the case, the same will hold good as in that of the first patient; probably the disturbances, now so well defined, will gradually clear up, while a more or less high grade of mental enfeeblement may remain.*

*The patient improved somewhat, but was twaddling and imbecile. He gained 24 kilogrammes in weight, and was taken home into family custody. Later on he went to a nursing asylum, where he died after the whole illness had lasted five years.

CASE 44. Catatonic excitement; toxic background. Strecker and Willey (13), p. 421.

Female, Irish American Catholic, aged twenty years, who had a parochial school education and was a salesgirl in a shoe store. She was one of 5 children. The father died of "stone-cutters' tuberculosis," and at the time of the onset of the patient's psychosis the mother was in a public hospital suffering from a "depression." The patient was social, good-natured and popular. The ordinary diseases of childhood were not important but acute articular rheumatism at fifteen years of age produced permanent heart damage.

Worry and grief over the mother's mental illness favored the development of the psychosis. The onset was abrupt, with much talk regarding three ideas which seemed wholly detached from each other: the mother was dead; the patient herself was to be married; a stranger was trying to dope her and carry her away. During eighteen days in the municipal psychopathic hospital she was "noisy, incoherent, disoriented, combative, silly," and a threatened collapse made it necessary to remove her to a medical ward. Under our observation for six weeks, she gave an almost classical portrayal of catatonic excitement. She was noisy and resistive, struck, kicked and bit anyone who approached her, broke glass, threw herself on the floor, knocked her head against the wall and was hopelessly untidy. There were also mutism, negativism, grimacing and mannerisms. Complicated fixed postures were assumed; for instance, the left leg was extended at full length, with the right bent at the knee and crossed behind the left at right angles. At the same time the left hand was held over the occiput and the right upward with extended palm. Both the expression of thought and of affect were widely separated from the behavior and from each other. The former was wholly incomprehensible and uninfluenced by questioning or external stimuli. It was dissociated, profane and occasionally neologistic. The following production was shouted without any evidence of any feeling: "Pick out my eyes—go kill me—nail me to the cross—you are brutes—that's it, cut my head off—I must die—you for the electric chair—you are one of the gang—the last for the electric chair—you are going to hell—there you stand looking at me—I am going to die." Usually, however, there was less connectivity: "Just blue—Vermont—not too many cakes either." It could be determined that memory was not interfered with. There was partial disorientation for time and person, the latter, perhaps, related to the fragmentary paranoid delusions. There were hallucinosis, "death bells," "shadows" of "her own ghost" and once a reference to a "gas" odor.

Physically the patient was anemic and was poorly developed. There was a loud mitral systolic murmur. A broken-down cervical gland discharged almost continually and it may have been tuberculous, since the lung findings were suspicious and there was a lymphocytosis of 38 per cent. An eosinophilia of 5.6 per cent was noted. A maculopapular eruption gave a culture of staphylococci, albus and aureus. The blood pressure read: systolic 108, diastolic 70. A dozen readings failed to reveal any temperature elevation.

The patient recovered exactly five months after the onset of the psychosis and, so far as we are able to determine, has remained normal and well for seven years.

Discussion of the Preceding Case. In spite of the recovery, the unanimous staff diagnosis of catatonic schizophrenia was justified according to the canons of strict clinical psychiatry. It is obvious, however, that the somatic factor was underrated. The patient certainly had heart disease, was depleted and possibly had phthisis and other infection. Catatonic reaction types in organic disease have often been observed and this possibility is of considerable importance.

CASE 45. Schizophrenia, illustrating dilapidation (hebephrenia). Dorcus and Shaffer (12), p. 290.

B. K. R., aged 28, female, single, college education, Episcopalian, art student.

Family history. There is nothing of importance in the family history with the exception of an "hereditary deafness" on the maternal side. The patient's mother and maternal grandmother were deaf, and the patient began to experience difficulty in hearing at the age of eight.

Personal history. That patient is the youngest of six children of an Episcopal clergyman. She was brought up by a nurse who was extremely indulgent toward her. As a young girl she was cheerful, lively and generous, and had many friends. Her father described her as being pure and very religious in adolescence. She was meticulous about keeping promises and very fastidious about personal cleanliness. She was always stubborn and exhibited much quickness of temper. From eight to thirteen she attended private school, and from thirteen to twenty-one she went to three fashionable boarding schools where she is said to have done well. Following her graduation she had a successful debut and traveled extensively with her parents. She would have nothing to do with men, would not even let them touch her hand, but had a good time with girls. She had a tremendous dislike for cats and flies and would touch nothing that they had touched. She began to experience difficulty in hearing at the age of eight, and this condition has grown progressively worse. During the three years previous to her breakdown she is said to have become increasingly more irritable, impatient and difficult to get along with. About nine months before her hospitalization she was in an automobile accident and received an extensive scalp injury. She fainted and was unconscious for ten minutes. Her mother was also injured in this accident, and the patient was greatly shocked about this and believed that her mother had been killed. After the accident, while the patient was spending her summer vacation with the family, it was noticed that she was acting rather queerly. She did not want to go out among people because they always talked about her head. She was irritable, stayed up late at night, got up early in the morning and took long solitary walks. At this time her sister's child had an operation for strabismus; the patient became rather attached to the idea and later decided that she too had strabismus. She often went walking with her nurse, an elderly woman who has looked after her since childhood. On several of these occasions she sat down on the curb and refused to move. On one occasion she insisted upon leaving the hotel at 11:30 at night to go for a walk. She came in considerably later and announced that it was cool and dark and she was by herself. She became increasingly more irritable and demanding, and at one time hid her father's purple robe because he was slow in granting a request. In this way she hoped to prevent him from going to church. There were periods of storms in which she would slam doors, break locks or any moveable article she happened to lay her hands on. She became interested in art, particularly the life class and spent much time drawing nude women. She broke forth in tirades against her parents, called them old hypocrites and said she never wanted to see them again. She eventually became so wild that it was necessary to hold her down for a time, on which occasion she burst forth to her father, "You ought to be ashamed to touch my knee. Why did you make so many men seduce me? You have mistreated me since I was six. I am already deaf—I am going blind—everything and everybody is against me."

Within the hospital she behaved in a silly, excited manner with much grimacing and silly laughter. Her talk was incoherent, irrelevant and difficult to follow. She talked a great deal about people being against her, mentioned the

power of the "subjective mind" and her ability to influence others. She repeatedly read absurd meanings into the things going on about her and at times believed that her mother was trying to kill her.

She talked at great length about holding hands with strange men in moving picture theatres and about several minor flirtations with married men and was particularly amorous toward the physicians in the hospital. She felt that in the ward she was influenced by the homosexual feelings of the women about her, saying "They get ideas into my mind—the idea they get across is like in 'The Captive' (a play) most of them have trouble with their eyes." This condition of the eyes she has definitely tied up with sexual tension, and she considers it to hold for her fellow patients. On one occasion she remarked, "Yesterday I was dancing with another patient and I got her all hot. I didn't know I could do anything for her eyesight."

The patient rapidly deteriorated, her speech became increasingly more incoherent and disconnected and her behavior typically impulsive and childlike. She perpetrated many childish pranks and spent considerable time in silly laughter with no paralleling humorous content. Anything that came to mind was blurted out, "That woman's painted like an Indian on war parade. I want some candy. I wore my shirt inside out for two days and none has come yet. Yes I have been to England four times—I saw the King and Queen. I would know them if I saw them again because they have blue hair now. I was a baby but I don't know where I came from." She became increasingly more silly and spent much time standing on a bench going through manneristic performances.

CASE 46. Schizophrenia, delusional type. Dorcus and Shaffer (12), p. 295.

W. P., aged 38, male, single, college education, manufacturer.

Family history. Although the paternal history is essentially negative, one maternal aunt died in a mental hospital, the mother was neurasthenic and a sister is in a mental hospital.

Personal history. The patient's early history, according to the information, was uneventful. He stood high in his class at Yale and was quite athletically inclined. While at college he won the inter-collegiate tennis championship and displayed fair prowess in other athletic events. After leaving college he was very successful for five years as the manager of a wire nail factory during which time he had considerable luck in playing the stock market.

The onset of the patient's difficulties appears to coincide with the beginning of his sister's mental illness. When the sister became ill, the patient and his brother took her West to a sanatorium. Upon their return the patient grew depressed and melancholy and lost his position with the nail company. The patient's father had, in the meantime, died and left him a large sum of money. A nurse was secured for him, and he travelled extensively, spending money freely. The family had great difficulty in breaking the patient's attachment to this nurse who, they believe, had a rather bad influence over him. It is stated that they always took communicating apartments wherever they stopped and had been on very intimate relations. The patient became increasingly irritable and excitable and developed exaggerated ideas of his personal prowess. He began to speculate in stocks and, interestingly enough, made fifty thousand dollars in these activities. Then he bought four automobiles at one time despite the fact that he had no use for them. He developed ideas of persecution, purchased a revolver and on several occasions fired this weapon in the air.

The patient's expansiveness steadily continued, but his delusional content evidenced no systematization. He declared that his name was Astor, that he had

wrestled with the champion and defeated him, that he had knocked out the heavyweight boxing champion, and that he had pitched a game against the Cleveland Americans and defeated them. He is now markedly suggestible and will declare that he is almost any celebrated personage that can be named such as John D. Rockefeller, or the President of the United States. He even frequently exposes himself in order to exhibit his imagined wonderful physique. Often he appears with several cuffs on one hand, his pockets loaded with wet towels and all sorts of things that he picks up and stuffs in them. He explains this by saying that he is trying to strengthen his side, that his left side is stronger than his right and that he is very anxious to make the latter stronger. All of his clothes are about four sizes too large for him in order, he says, to give the muscles a chance to expand. At one period of time he had a habit of darkening his eyebrows with either shoe polish or ink and he occasionally washed his head in ink because, he states, all of the pugilists and ball players of the country stain themselves. He entertains all sorts of delusions, claims that spiders and snakes come into his room at night and bite his eyeglasses, a fact which explains their being chipped. If he loses a pin or a collar button, he will say that magnets pass through the air and take the pins out of his necktie. He rides horseback several times a week, and upon his return, tells the most outlandish tales with reference to his experiences with his horse, when as a matter of fact, the horse which he rides is perfectly gentle. At a baseball game he is under the impression that he is the center of attention, that the players, when they look at the grandstand, are looking at him. He also claims that he knows all of the players and cites several games when he pitched against them. In dancing he pays little attention to other couples on the floor and therefore is frequently running into them. He has undergone considerable mental deterioration, and his emotional apathy is well evidence by his indifferent attitude to distressing facts that have been presented to him.

CASE 47. Latent homosexuality in schizophrenia. Hutchings, Cheny and Wright (14), p. 164.

The second patient upon whose reaction we wish to comment is E. F. D., a young man of thirty-one years, of slender build and frail appearance. Numerous members of his family have been alcoholic and psychopathic for three generations. He was always a "home" boy and lived with his mother and sister, whom he supported.

He always had difficulty in meeting people and was a poor mixer with both men and women, but had held good positions successfully and was earning thirty dollars a week.

One evening four years before his admission to the hospital he attended a party for men, where all were drinking. One of his companions did him a favor, upon which the patient impulsively threw his arms around his neck and kissed him, and called him a good friend. The next day one who had been present at the party the evening before, teased him about the incident and said: "I never kissed a man when I was drunk. There must be something queer about you. I never see you around with girls."

He reacted to this incident with anxiety. He thought that others regarded him as a pervert and he misconstrued casual remarks made by his associates as accusing him of immoral practices. He spoke of them as "double-edged remarks." His condition progressed rather rapidly. Although he still remained at work, he expected to be discharged from his position on account of the false and libelous stories which he thought were being circulated against him. Six

months later he hallucinated. At that time strangers passing him on the street made insinuating remarks such as, "That's the fellow, there he goes," or they openly accused him of being a pervert saying, "There goes the c.s. That is the guy." Soon he believed that he was followed by detectives employed to "frame" him and establish his guilt.

At the office where he worked he noticed the men often placed their hands in the region of their genitals. This was a gesture accusing him of being a pervert.

Though he had formerly worked only in his native city he now went about from place to place. He seems to have secured work easily as a telegraph operator but did not remain long in one town because the persecutions soon became intolerable. He attributed them to the Masons who, he thought, had been led to believe that he had revealed some of the secrets of the order.

In the wards of the hospital he was anxious and tense and begged for protection against being framed as a pervert, insisting that he had always led a clean life. Once when speaking of this subject he said, "Doctor, the fellows who really do these things do not worry at all, but I am worried all the time."

During the mental examination he anxiously inquired: "Doctor, do you think venereal germs were planted in my throat? I think it was done to destroy any alibi of mine." This question was prompted by a routine examination of the nasopharynx in search for diphtheria carriers.

He stated to the physician that he would have killed his tormentors, but fear of punishment deterred him. "Doctor," he asked, "if I should go to Matteawan or Dannemora would I have to get down on some of those fellows?" He was afraid that any little act which he might do could incriminate him in the eyes of others. He said: "If I do this or if I do that I am a fairy."

He has made four impulsive attempts to commit suicide by breaking windows and cutting himself with glass. For a long time now he has gone about holding his lips tightly pursed and his hands over his mouth.

Doctor's comments: This is a paranoid psychosis beginning at the age of twenty-seven years in a man who had previously shown no evidence of mental disorder. Its beginning can be fixed on a certain evening four years ago when he was drinking with a party of his men friends. He had frequently attended such drinking parties and had become intoxicated on other occasions but with no other bad effects. The favor which the friend had done him was to help him to the water closet when our patient had become nauseated, to support his head while he had vomited and afterwards lead him back to his seat. In other words, the friend had mothered him, and the patient had responded to it with a kiss, as a child would under the circumstances.

In this case we are permitted to see not only the precipitating cause (the incident and teasing by another friend on the following day), but also the so-called constitutional factor. He had reached the age of twenty-seven years without having "been around with girls." He had manifested no interest in the other sex except in his mother and sister, with whom he lived. He was well behaved except for rather frequent sprees when he drank to excess, always in the company of men. He did not make friends readily and was ill at ease when among strangers in a social way.

His homosexuality was, as it usually is, due to the fixation of his emotional interest, love, upon his mother in the immature pattern of the child. Normally this feeling toward the mother undergoes a developmental change at puberty, or earlier. The libido gradually detaches itself from the mother so that by the time the erotic element of love becomes dominant it no longer recognizes the mother as the principal love object This development had not taken place. The

genital zone had not taken full command of his erotic interest: the oral region retained a dominating share. That he had not previously recognized his homosexual cravings is evident from his panicky reaction when his attention was called to their presence by the remark of his friend. Until that time his alcoholic sprees seem to have afforded him a sufficient outlet. The bantering remark would doubtless have been passed off with a goodnatured retort had he not stood convicted in his own eyes. His psychosis is the expression of the conflict waged in his own mind to keep from conscious acceptance that which he unconsciously and instinctively recognized to be true. Recovery could take place only by his accepting passive homosexuality as his lot and harmonizing it with his personality. Having previously adopted certain standards of manliness, this acceptance was impossible and he was condemned for the rest of his life to carry on this pantomime of protecting his ego against the perverse erotic cravings by projecting them upon outside malevolent agencies.

His psychosis throughout has been characterized by a fight against giving way to his homosexual cravings and the fear that persons around him would believe he was a homosexual. That this struggle with homosexuality is not the fundamental difficulty is indicated in the fact that no amount of discussion with him regarding the homosexual component in all men, or reassurance that he is not thought less of because of any possible homosexual tendency, has any effect in bringing about a more normal adjustment in his life.

IV. PARANOIA AND PARANOID REACTION TYPES

CASE 48. Paranoia, classical type. Kraepelin (10), p. 148.

The master-tailor, aged forty-two, whom I wish to show you as an example of another form of the disease described here, has had a still more obstinate struggle. Seven years ago he became insolvent, and at that time fought out fierce lawsuits with the attorney of a principal creditor. Later on he removed to another town, but could not get on there, and fell into debt. Four years ago he had to leave a house that by purchase passed into other hands. The new owner, as vindication of his claim for rent, wished to have part of the furniture brought back through the bailiff, but was met by violent opposition, the patient simply locking up the bailiff as well as his companion, in order that meanwhile he might be able to lodge a complaint in court himself. He was accused of false imprisonment, and punished.

A short, humorously treated notice of this affair appeared in a daily paper, in which the incident was incorrectly described as "distraint," and it was added that the accused had an intense hatred for the bailiff, who had been a frequent guest of his. Our patient was very angry about this statement, and sent in a correction, which was only printed in part, and consequently did not satisfy him. He wrote an enraged letter to the editor, which was answered by a report in full of the further course of the proceedings, which went up to the Supreme Court. That the title "master-tailor" was printed in large type put the patient into the greatest excitement, and caused him to bring an action in the first place against the editor for private insult, then an action for compensation on account of damage to credit, and, lastly, an announcement of punishment on account of gross misdemeanour.

All these complaints were rejected by the court on account of insufficient grounds. The patient did not rest satisfied with this judgment, but gradually set in motion every means imaginable in order to attain his end. First, he went through the usual stages of appeal, up to the Provisional Court of Appeal and the Supreme Court of the Empire; then came the complaint, the revision, the petition for appeal, the petition referred back to its original position, further petitions to the Ministry of Justice, to the Ministry of State, to the Grand Duke, and to the Emperor, besides to the Court of Administration and to the legal Government official. Petitions were also planned to the Diet and to the Federal Council, and interpellation of the Chancellor of the Empire in the Reichstag was planned, because he was answerable for the execution of the law in the Empire. Lastly, on the refusal of the judges and courts of justice, the patient tried the experiment of complaints to the heads of the courts, and held out in prospect the proposal of disciplinary proceedings against the Public Prosecutor before the Grand Duke, as well as a piteous appeal to the public for the support of legitimate interests.

The innumerable petitions which the patient has drawn up in the course of the last few years, chiefly at night, according to his statement, are exceedingly long-winded, and always allege the same thing in a rather disconnected manner. In their form and mode of expression they incline to the legal document, beginning with "Concerning," going on throughout with "evidence," and concluding with "grounds." They abound in half or wholly misunderstood professional expressions and paragraphs of totally different laws. Often they are careless, and appear to have been written under excitement, contain numerous notes of exclamation and interrogation, even in the middle of a sentence; one or more

underlinings, some in red or blue pencil; marginal notes and addenda, so that often every available space is made use of. Many of the petitions are written on the backs of judgments and refusals of other courts.

In consequence of this incessant pestering of the authorities, the patient was at last pronounced to be mentally deranged, but against this opinion he adopted every possible legal means of redress, and at the injunction of the Highest Court of Appeal will now once more and conclusively be passed judgment upon by us. He has meanwhile carried on his business even under great difficulties, and, apart from his petitions, has not become strange or troublesome.

If we now allow him to speak for himself, you will see that the patient is not only clear as to his position and gives a consecutive history of the events of the past, but is also able to express himself with great volubility and readiness for battle on the subject of his lawsuit. He does this evidently with a certain inward satisfaction. He is never at a loss for an answer to objections, but justifies his action by the quoting of ever-new minutiae, principles of jurisprudence, and law paragraphs. In prolonged conversation a wearisome diffuseness certainly appears in his narrative, and the inclination to jump from one line of thought to another, but always to return in the end to the same expressions and amplifications. It can be seen from this that the patient looks upon the plaintiff's attorney, who co-operated in his bankruptcy proceedings, as the real source of his misfortunes, although he has not come into contact with him for six years. But when he wished to bring an action against the editor of the newspaper, the clerk of the court, referring to that earlier lawsuit, at first dissuaded him from it.

By this it became clear to the patient that the attorney had prejudiced the clerk of the court against him, and furthermore sought to ruin him. All subsequent misfortune was only the result of this influence. The clerk did not draw up the accusation properly, so that it could not be carried through; the Public Prosecutor got a wrong view of the matter from it, and the judges of the several law-courts, out of deference to their colleagues, did not wish to reverse verdicts once agreed to. They were as a body "prejudiced." His affairs, therefore, in this particularly exceptional case, had been obliged to be referred to another court. Thus had the course of law been "systematically obstructed" to him. The whole business was a "secret conspiracy"—"Freemasonry," for he assumes that his enemy had gone among the Freemasons. The whole body of Jewish financiers play a part in it, because the daily paper that wrote about him is, according to his opinion, supported by them. Also associated with the attorney are the "brigands of the press," the "Jewish sacrilege," the "subterfuges of the courts," the "violation of justice" by the attorneys appointed to him by the court, with whom he immediately fell out as soon as they did not follow his instructions, and, lastly, the incapability of his trustee, who throughout understood nothing of legal affairs.

The patient's idea of being wronged goes back to one solitary fixed source, but it has gradually involved and brought into connection with one another a whole series of persons who worked together, after a secret plan, for his ruin. This way of looking at things is everywhere supported on real occurrences, which are judged and interpreted by the patient alone in quite a one-sided manner. We see here plainly how that idea has developed to a kind of viewing of the world which affects in the most influential way the working-up of the later experiences of his life. In addition to this, the patient is quite impervious to reason. It is quite impossible to get him to admit that he may perhaps have been mistaken in his interpretation of the occurrences. On the contrary, he at once becomes mistrustful if one urges him on this point; mere contradiction arouses in him the suspicion that we too are bent on supporting his opponents.

All these features, the connection of the ideas of being wronged with a common starting-point, the extension of these in ever-widening circles, and, lastly, the imperviousness to reason, show us that we have here to deal with a delusion which takes deep root in the mental personality and is worked out into a system. There obviously exists along with it a certain weakness of understanding, which shows itself in the monotony and aimlessness of his line of thought, as well as in his inaccessibility to the most obvious influences. His memory is generally correct, although, on closer examination, many of his assertions and wordy statements are found to be not quite reliable.

In the emotional province we notice first an increased self-confidence. The patient displays a certain superiority, likes to show off his legal knowledge, and, in spite of every failure, expects a happy ending to his affair. He has no hesitation whatever in again and again troubling the highest quarters with his petitions, for he looks upon his affair as one of quite special importance. As "a German and the father of a family," as "a man of business," he holds his "legal instinct" to be more authoritative than all the judgments of the courts. At the same time, he is exceedingly touchy, and answers each unfavorable verdict with the coarsest invectives, accuses the witnesses of perjury, the judges of corruptibility, speaks of "political-religious poisoning of wells," but says withal quite ingenuously that he always moves "within the bounds of propriety" himself.

But the most striking point is the senseless action of the patient during the last few years, by which he has brought himself and his family more and more deeply into misfortune. He recognises this, but lays the whole blame on his opponents and the courts, who had forced him into it, and from whom he demands ever-increasing amounts of damages. It remains incomprehensible to him that he would now do best to acquiesce, and to spend all his energy in gaining a livelihood. On the contrary, he is already considering what way still remains open to him for making good his rights, should our verdict prove unfavourable to him also.

CASE 49. Paranoia; psychosis. Henry (15), p. 79.*

The psychosis had been developing over a period of several years although the exact duration could not be determined. The history states that at the age of forty-five the patient left a large legal practice in Germany and without adequate reason suddenly came to America with his wife and five children. After this he developed persecutory delusions and as a result neglected his business, wasted his money and kept the home in a turmoil. Just before admission to the hospital he conceived the idea of offering up his family to aid his plan for the regeneration of the world. He said that he had corresponded with and was a suitor of the Queen of Spain and that he had been persecuted for a long time by the Grand Duchess of Baden and other exalted personages; that his servants had given him poison in his food; and that by means of a system of mysterious figures and symbols which he had discovered he possessed an unusual power to detect the machinations of kings, queens, duchesses and other royal personages. He had covered reams of paper with these mysterious letters and symbols. He walked the floor for long periods of time declaiming his wrongs in a loud voice. He had persecuted his sister-in-law by shouting at her in public places and he refused to eat with other members of the family.

For many years after admission to the hospital he continued to express these delusions. He probably still harbors them although he has not spoken to anyone for more than twelve years. For over ten years he insisted upon sending affectionate cablegrams and letters to the Queen of Spain and he became in-

*This and cases 52, 53, 54, 55, 58, 72, and 79 reprinted by permission from Essentials of Psychiatry by G. W. Henry, published by Williams and Wilkins.

furiated when his wishes were not granted. After repeated failure in having these messages forwarded he demanded that the following cablegram be sent to the Queen: "To avoid misunderstandings herewith I formally give notice to your Royal Majesty that all kind of unfair treatment by unspeakable Turks well known absolutely despicable extortion tricks hereabouts caused me the third time to resign. My correspondence now free. Informatory letter follows. Position fully upheld. Hope you in best of health and spirits. Thoughts and wishes as always."

While in a communicative mood he confided to one of the physicians that by means of his occult power and calculations he had obtained the following information: that the Duchess of Baden had caused his mother's death and for this she would be publicly hanged; that he was a descendant of Napoleon I and that the Queen of Spain had the same ancestry; that Bismarck was also a common ancestor; that the Emperor of Germany was occupying the throne which belonged to him; that the Queen of Spain had only recently come into her titles and that by the same means he would soon come into his; that his legal father was an imposter and that his real father was actually a French nobleman. In talking about these subjects he was very much in earnest and at times he became quite excited over the imagined injustices he had experienced.

Some time later he expressed the delusions that his mother, who had died twenty-five years before, had come to life again and was coming to see him; that his wife had died and he would soon remarry. For some time he denied his identity, claimed that he was Duke Guylia and denied that he was in any way related to the other members of his family. At one time he claimed that he had been hypnotized by his persecutors and that while he was under their influence they had made an ass of him. For several months at a time he refused to eat and had to be tube fed. This refusal to eat occurred in relation to his chagrin at not being able to continue his communications with the Queen of Spain. He made no objections to being tube fed and in fact at times requested it saying that he "wanted the sensation."

After having received treatment in a hospital for more than twenty years there has been apparently a gradual tendency toward a quiescence of his psychosis. He still however shows an attitude of exaggerated self importance, a constant feeling of being ill humored, and refuses to have anything to do with his family. He slams the door, shrieks and stamps his feet when anyone comes near him. He indicates his wants by means of gestures and interjections. At the same time he is quite alert to his surroundings and shows very little evidence of mental deterioration.

This case illustrates very well the ways in which ambitions and emotional and instinctive cravings are satisfied by a psychosis. The fact that the patient believes that he is persecuted by kings, queens and duchesses in itself enormously magnifies his importance. If he were an ordinary individual he would not even be noticed by these exalted personages. Later in the development of his psychosis he becomes certain of his importance because by means of his "occult power" he learns that his real father was a French nobleman; that he himself is a distant relative of the Queen of Spain and that he would be the Emperor of Germany if it had not been for the jealousy and machinations of other exalted personages. All of this is out of harmony with the fact that he is merely a lawyer, has a not unusual wife and family and actually has a very limited amount of power or influence. The initial solution of this disharmony is seen in the beginning of his psychosis by his partial withdrawal from the immediate family. This is shown by his abuse and refusal to eat with them. Later in the psychosis his unconscious desires are expressed in the conclusions that his wife is dead, that he is not in any way related to the members of his family and

that he is really Duke Guylia. Therefore he quite naturally expects soon to "come into his titles" and to marry the Queen of Spain. It is not surprising that he is a very haughty individual and becomes infuriated when his wishes are not immediately served.

It should be said in passing that his interest in being tube fed, "wanting the sensation," suggests a revival of feeling associated with homosexual experiences or tendencies. The resurrection of his mother (the only relative whom he has not disposed of in his psychosis) restores the premarital mother-son relationship with its pleasant emotional and instinctive attractions. In short, the mother fixation, a common antecedent of homosexuality, has triumphed over the emotional ties of adult life.

CASE 50. Paranoia; erotic type. White (16), p. 134.*

Family history shows nothing worthy of note. Patient's early childhood presents no abnormalities. He had a common school education. At the age of ten, he had quite a severe illness. While working on his father's farm he conceived the idea of becoming an inventor, which his folks discouraged so greatly that he left home and went to Chicago, where he worked as hostler and coachman, giving excellent service. In 1899, he obtained his first patent, it being for a special bicycle hub. In connection with his attempts to make this patent a financial success, he first showed ideas which might be termed paranoid. The man to whom he gave a half interest in his patent failed to manipulate the stock of the company which was incorporated in proper manner, and the people who became interested in his proposition he thinks were mostly sent by other manufacturers to discourage him in his attempts to make something out of it. In 1906, he patented a brush which he induced the Pullman car people to try, but they were not a success because of the activities of the whisk broom manufacturers, who, in league with the porters, caused them to be returned as defective. He has continued up to the present time manufacturing these brushes in a small way, and devoting his time to perfecting machines in order to increase their output. According to his statements he has a financial rating of $1,000, and says he would have more money had he not spent so much in models for his machinery. Among the pamphlets which he has gotten out for advertising purposes was one dealing with American wealth marrying foreign titles, which he wrote about the time Miss Katherine Elkins and the Duke of Abruzzi were prominent names in newspaper headlines. With this article he had his picture published, one taken about fifteen years ago, when he said he was a very handsome man. He denies the use of drugs, and rarely takes a drink. He masturbates at least once a week, and sometimes oftener.

About three years ago while visiting in Washington, he dropped into the National Museum to look over some propeller models. He believes that Miss Katherine Elkins entered the building carrying a coronet in her hand; that upon seeing him, she said: "There is the man who caused me to do this. He is not so handsome as his pictures, but his writings are so penetrating." From this statement, he became convinced that Miss Elkins had obtained one of his pamphlets, had seen his handsome picture, and as a result, had broken off her engagement with the Duke. A short time later, he saw her again in his Chicago bank, motioning to him to come to her. A year later while in Washington, he again saw her in a carriage on Pennsylvania Avenue. He heard her call to him. Once while walking along a street in Chicago, her sudden appearance before

*This and cases 85 and 86 reprinted by permission from Outlines of Psychiatry by W. A. White, published by Nervous and Mental Disease Publ. Co.

him he believes to have saved his life, as it caused him to halt, just as a man fell from a ten-story building to the pavement at his feet. A short time later, he saw her walking along the street, and heard her say to a woman companion, "I do not object to him because he is poor." Sometime this last summer, a somewhat cultured looking old man, purposely dressed rather shabbily he thinks, came to room with the janitor of the boarding house, directly across the hall from his room. He believes that this old man and several others who stayed a shorter time were agents sent by the grandfather of Miss Elkins to observe his life. Of this he was rather glad, for he wanted the Elkins family to know that he lived a clean, irreproachable existence. Ever since the occurrence at the National Museum, he has written quite regularly to Miss Elkins, and because he has received no reply requesting that he cease doing so, believes she gave her consent to his correspondence. When about a year ago he called at the Elkins home, to see Miss Elkins, and was rather brusquely turned away, he conceived the idea that the family knew of her love for him, and was attempting to keep her from seeing him. Some time this fall, intending to make his annual trip to Washington, he wrote a letter proposing to Miss Elkins, and on his arrival in the city went to her home on K Street to have the matter settled one way or the other. However, when he called at her home, he was requested to call that afternoon. During the day, he busied himself talking with a patent attorney on the advisability of patenting a model which he had constructed demonstrating that the earth's axis is horizontal instead of perpendicular. When he went for his noonday lunch, he had to wait so long for what he had ordered, that he believed that he must have been doped by parties who were bent upon preventing him seeing Miss Elkins. When he returned to the Elkins residence, he was adroitly conducted to the police station. He was taken to the Washington Asylum Hospital, where he saw Miss Elkins come in to lead him out; he is sure it was she by the warmth of her hand.

Medical certificate states that patient is not addicted to the use of narcotics. The first symptoms became manifest by patient requesting protection from the Attorney General for his patent rights. Present symptoms: Patient says he has a patent for making brushes and that they are so good and so widely used, that the other manufacturers are jealous and attempt to harm him. They go around quietly and destroy his brushes. He has made a model of the earth and sun, which shows that the present knowledge of astronomy is incorrect. He says if the other manufacturers got a chance, they would do him bodily harm. He says his patent rights are worth from one to five million dollars. He has also invented a patent flying machine which is altogether different from any of the 1911 models. He says it is different from any on the market. He has also invented a motor boat propeller which is a great improvement on the existing ones. Says that a certain party is having him watched. This man is jealous of him on account of a woman. Says he is the best inventor living. Says some time ago he wished an enemy of his would die, and he died. Saw a vision. No homicidal or suicidal tendencies.

Since patient has been here, and thought over some of the past events, he believes that a man who came to visit him in Chicago put some dope in the cigar which he was smoking. He seems much concerned as to the little business which he is conducting in Chicago. He states that if he were free, he would go directly there and not return to Washington, and drop this love affair entirely. He laughingly states that the idea which his model illustrates regarding the earth's axis will some day be taught in the public schools, and it will be said that he, the discoverer, was arrested, tried and adjudged insane the first day he presented it.

CASE 51. Paranoia; litigious and erotic type. Bluemel (9), p. 421.

Mr. White was a young lawyer who became associated with an older lawyer, Mr. Jenkins, as a result of their mutual interest in civic affairs. White made several social calls at Jenkins' home and here he fell in love with Jenkins' sister. However, his suit was rejected for the reason that Miss Jenkins was already engaged. This situation created the suspicion in White's mind that Jenkins had prejudiced his sister against him. Accordingly he continued to pay court to Miss Jenkins, but his advances were repulsed. Finally Miss Jenkins left Denver and went to Kansas. White followed her. She fell ill and was taken to a hospital. White persisted in his attempts to see her. Miss Jenkins died and White insisted on seeing the body. The hospital authorities acquiesced, and when White expressed doubt that Miss Jenkins was really dead, a nurse turned to the body and lifted an arm in order that he might see it fall limp and lifeless on the bed. After these experiences White returned to Denver where he shortly expressed the delusion that Jenkins had faked his sister's illness and death, and that the alleged corpse was a dummy. He averred that he had heard the arm squeak when the nurse dropped it. He became more and more hostile toward Jenkins and finally threatened his life with a gun. Jenkins preferred lunacy charges against him and White was tried before a jury. He conducted his own defense, and in true paranoid style he repudiated his delusions. He admitted that he had said and done all that was charged against him, but explained that he had been overwrought, and that in his calmer judgment he no longer entertained the delusional beliefs from which he had formerly suffered. In this manner he secured his acquittal, but before he left the court he called one of the psychiatrists aside and insisted that he had in reality seen a dummy corpse at the hospital and that he had indeed heard the arm squeak. Again he began persecuting Jenkins, and again much of the procedure repeated itself. There was a second lunacy trial, a second able defense by the patient himself, and a second acquittal. White now went to California. He failed miserably when he attempted to establish himself in the practice of law, and he came to the conclusion that he was unable to succeed because of the presence of Jenkins' emissaries. While in California he married a woman who apparently was also a paranoiac. Shortly the couple returned to Denver, where they filed a number of lawsuits. White sued practically everyone who had opposed him in his previous trials, and he sued the newspapers which had published accounts of the trials. He made claims for damages in excess of a million dollars. His wife brought eighty-five lawsuits on her own account. Meanwhile White continued to harass Jenkins. He rented a room which overlooked Jenkins' yard across an alley, and he would sit at the window with a rifle in his hands. One day he called at Jenkins' house, apparently in a peaceable mood, and demanded an apology. Members of the household called the police and it was found that Mrs. White was carrying a revolver in her muff. As a result of these episodes White appeared a third time before a jury to defend his sanity. At this hearing his arguments were unsuccessful, and he was adjudged a lunatic.

CASE 52. Paranoid reaction with recovery. Henry (15), p. 82.

A druggist, forty-six years old, who suffered from a paranoid condition. He was described as being ambitious, energetic, fairly self reliant, passively sociable, serious minded and very conscientious, and with inclinations toward jealousy, irritability and a quick temper. In general he gave the impression of being a rather harmless, insipid type of person with possibly less than ordinary intellectual ability. He was actually unsuccessful in business and finally a few

years before his illness he obtained a position as clerk in a drug store belonging to a former successful classmate.

It happened that he was still a citizen of Germany at the time the United States declared war, although he had been a resident in the latter country for twenty-five years. Although he was not pro-German in his sympathies he imagined that people doubted his fidelity to the United States and suspected that he was being watched by spies. He even thought that his wife and employer were watching him. When a stranger asked him for directions on the street he misinterpreted this as being part of the work of spies. During the war he occasionally mentioned his suspicions but there were no other indications that he was not well. Nothing special was noticed until one day a sudden vexation with his wife because she could not find a collar for him caused him to announce that either he or she would have to leave the house. As his wife had no such inclinations he departed that night and for the next three months lived at a hotel. In the meantime he continued to contribute to the support of his family and occasionally visited them. On Thanksgiving night he had a brief psychotic episode in which he was found trembling and talking in a peculiar way about "two parties spending vast sums of money upon him." At Christmas time he "seemed tired out," "looked very peculiar," and remarked one evening that "they even knew that I bought collars," as though he suspected that some one was continually watching him. About two weeks later, after he had been impatient with customers in the store, his employer suggested that he take a vacation, telling him that he had been overworked and "under mental strain." As a matter of fact he had been working unusually hard for a long time with scarcely enough time for eating and sleeping and none for recreation. An element of exhaustion undoubtedly contributed to his illness. It should be stated also that during the previous year he had been interested in a dancing teacher but only to the extent of sending her flowers and chatting with her in the store.

While in the hospital he was somewhat reserved but otherwise appeared normal. He seemed to recognize that his peculiar ideas and experiences were largely imaginary. As his physical health improved through rest, proper food, moderate amounts of exercise, recreation and occupation, there was a corresponding improvement in his mental health.

This patient represents a type of person who under ordinary circumstances might not have developed a psychosis in spite of his limitations. Under war conditions the fact that he was still a citizen of a hostile country made him feel that he was being closely watched. These conditions in addition to the stress of physical exhaustion from excessive work caused a temporary failure of adjustment between himself and his environment. Relief from these unusual stresses resulted in a return to his normal condition.

V. TOXIC REACTION TYPES

CASE 53. Toxic psychosis; endogenous. Henry (15), p. 146.

The following describes a case of toxic psychosis occurring in a young man twenty-three years old who had never before been ill. This psychosis represents a complication which occasionally arises in connection with acute physical disease. In this case it was associated with the infection and toxins of acute catarrhal jaundice.

His illness began with general malaise, headache and soreness in the muscles. He was unable to work and spent most of the time in bed. Four days later nausea, vomiting, fever and marked jaundice had developed. After about two weeks he was apparently convalescing satisfactorily and it was four weeks after the onset of the illness that psychotic manifestations appeared. Then one day he began to talk in an hilarious manner and at four o'clock the following morning suddenly became excited, saw snakes and bears about him and seemed afraid. After that he talked disconnectedly about being "mixed up" and about killing himself and other people. At times there were marked fear and excitement. A week later he was admitted to a psychiatric hospital in this condition. A sample of his talk on admission shows peculiar disconnected ideas and a mild paranoid trend. "These different schemes they are working on me—worrying me to death—you have got all my ideas and it's a shame too—you got the last people in the world to help you—the Pope and the kings and the birds and snakes—you're dragging down the people instead of raising them up—my bed screeches—my life just goes as far as my father—he was white—he was in Heaven but that doesn't do the Chinese any good now—different people got the signs by putting electricity into operation." At times he was fairly well in touch with his surroundings, while at other times he was completely disoriented. He gradually became more quiet, clear in his thinking and appreciative of the fact that he had been sick. In the meantime there had been a marked improvement in his physical condition. Psychotic symptoms were observed for a total period of three weeks and he was discharged as reoovered nine weeks after the onset of his illness.

CASE 54. Toxic psychosis; exhaustion. Henry (15), p. 147.

A case of toxic psychosis in an army officer, thirty-seven years old, was caused largely by physical exhaustion. He had seen active service for over three years during the World War, had worked for long hours, often with improper or insufficient food and had had practically no recreation or opportunity to rest. He had lost a great deal of weight and strength. He finally became confused and was placed under observation. On admission to the hospital he was very poorly nourished and thirty-five pounds under his usual weight. His tongue was coated, red, fissured and slightly swollen. He appeared older than his age and was described as a "hatchet-faced, hollow-eyed, weary looking man." There was coarse irregular tremor of the fingers and of the tongue and lips in speaking. His gait was so unsteady that he seemed to be intoxicated. In some respects his condition suggested general paresis. Laboratory tests and the subsequent course however proved that this was not the case. There was a varying amount of confusion which was noticeable chiefly at night. In going to a toilet a few doors away from his room he lost his way. He groped about his room looking under the wardrobe and bed for something about which he felt vaguely uncertain. One time he said he was looking for a cigarette. His memory of the events of the preceding two months was hazy. This condition continued for a few weeks, after which he improved rapidly.

CASE 55. Toxic psychosis; infection and exhaustion. Henry (15), p. 148.

A case of toxic psychosis in a man thirty-five years old was due to infection and exhaustion. After some months of convalescence there was a marked change in his symptoms due to the development of a post-infectious psychosis. For two or three years this patient had been complaining of "stomach trouble" for which he had had repeated surgical operations. For six months after the last operation (repair of hernia through site of incision of former operation) he had severe attacks of diarrhea which were found to be due to amoebic dysentery. These attacks caused him to lose seventy-five pounds in weight. He became so emaciated and exhausted that death was expected. After being sleepless for over a week he developed an acute toxic psychosis characterized by delirium and an extreme excitement in which he "prayed at the top of his voice, repeated verses and made speeches." This condition lasted over a month after which time he gradually improved. In the meantime the diarrhea had stopped. He improved sufficiently to be able to take a sea voyage. He did not recover his former health however and it was noticed a few months after this acute toxic psychosis that he lacked interest, had little to say and was apparently depressed. In the course of several months he arrived at a condition in which he was remorseful, prayed a good deal, begged his friends for forgiveness and tried to mutilate himself. On this account he was admitted to a psychiatric hospital, six months after the first psychosis. For some weeks he had to be watched carefully and at times kept in restraint on account of desperate suicidal attempts. Voices accused him of "terrible perverse sexual acts," said that he was to be killed and told him to make a sacrifice of himself. His recovery was gradual and accompanied the improvement in his physical condition. For a month or two before leaving the hospital he gradually assumed charge of his business and at the time of his discharge, a little more than a year after the first mental symptoms had appeared, he had entirely recovered.

CASE 56. Hyperthyroid condition. Henderson and Gillespie (16), p. 411.*

Summary: Nervous uneasiness for some years; retrosternal oppression; sudden gastro-intestinal upset following domestic worry; anxiety; attacks of palpitation and diarrhoea brought on by exertion; tumour in neck; extreme anxious precautions; hyperthyroid signs; operation, and toxic adenoma removed; recovery.

Mr. P. S., age 54. The patient complained of paroxysmal palpitation which disabled him for work, but his wife complained that he took undue care of himself and lived in constant apprehension of his heart attacks.

Personality.—He has always been sociable, happy, talkative and over-ener-energetic. His wife, on their first meeting, thought him the "most nervous man" she had ever seen: he was constantly active, laughing, talking and joking. His troubles he kept always to himself. Never until his present illness did he give any thought to his own health, which was always apparently excellent. He married at 32.

Present Illness.—The patient had a feeling of nervous shakiness for an indefinite time (some years). In December 1920 or thereabout he began to have a dull feeling in his chest, especially after exertion, sometimes amounting to actual pain. One night in March 1921, following a certain amount of emotional disturbance, he suffered from nausea and diarrhoea. In the morning his wife accidentally observed that his heart was beating very fast and pounding against his ribs. The patient himself had noticed nothing of this. A doctor was called in who,

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knowing of his over-active disposition and his alcoholic habits, tried to scare him into taking greater care of himself. He succeeded so well that the patient had rarely done a whole day's work since.

Attacks of palpitation occurred at intervals of about two weeks during the eleven months preceding admission to hospital (May 1923). They were usually brought on by exertion. The attacks varied in duration from two to twenty-six hours and left him very tired. He always lay down during an attack. One attack in particular, which occurred in May 1922, left him prostrated and unable to do any work until July. The attacks were always accompanied by diarrhoea. He slept well, but during an attack of palpitation his sleep was broken. He lost about 20 lb. in weight. About two months before admission he noticed, for the first time, a slight swelling in his neck.

Since the beginning of his illness he lived in the fear of precipitating an attack, and of a possible complete disablement if the palpitation should become permanent. To avoid this catastrophe he greatly limited his activities, both in work and recreation. He frequently counted his pulse, and observed his cardiac pulsations in a mirror. When an attack came on he lay down, no matter where he had been. He once lay down on a sidewalk in New York City and was soon surrounded by an inquisitive crowd. On his doctor's advice, if an attack came on in his office, he immediately took a taxi home. His attention to his business consequently suffered. He moved his domicile to within two blocks of his office. Even this proximity did not reassure him, and he frequently took a taxi. His friends, observing no special change in his appearance and no apparent reason for his complaints, insinuated that much of his trouble was mental.

He was a thin, sallow-complexioned man. He was intelligent and co-operative. His activity was of the "nervous" type. There were rapid changes of expression when he spoke, he laughed readily, and frequently movements of his hands occurred while he was talking. Even in ordinary quiet conversation a tremor of face and hands was evident, and as he lay in bed he threw off the bedclothes because he felt too hot. During examination he frequently felt his pulse, which was 100 in the recumbent position. He had several attacks of auricular fibrillation while in hospital, which were confirmed by electro-cardiogram.

There was fine tremor of the facial muscles, tongue and fingers. Von Graefe's sign was present.

There was a firm non-pulsatile swelling in front of the lower part of the trachea, and on either side of the mid-line, especially on the right side. It moved with swallowing, and there was a systolic bruit over it. The basal metabolic rate was-+29, and the urine had a trace of albumin.

The patient was operated on, and the left half of the thyroid removed. It was found to contain toxic-adenomatous masses. His recovery was uneventful, with the exception of one recurrence of palpitation in the first few days following operation. He returned to business and a year later reported that he was in excellent health, had had no recurrences, was putting on weight and was free from anxiety.

CASE 57. Chronic alcoholism; with hallucinations. Rosanoff (23), p. 382.*

J. B., male, painter, married, admitted to the state hospital at Kings Park, N.Y., on July 19, 1907, at the age of 36 years.—The patient's wife stated that he had been a hard drinker for years, and that he had drunk to unusual excess for several days prior to the onset of his psychosis. She also stated that he was of phlegmatic temperament, "unless drunk." The patient himself later stated

*This and cases 61, 68, 75, and 80 published by permission from Manual of Psychiatry and Mental Hygiene by A. J. Rosanoff, published by John Wiley & Sons, Inc.

that his custom had been to take a couple of drinks of whiskey and 3 or 4 glasses of beer daily "and maybe more," that often he was stupid from it, but yet he "did not swim in it."—On July 5, 1907, he came home drunk and acted irrationally; said he had $245,000 in the bank, that people wanted to murder him; he would not go in the house, made a disturbance, and was taken to the police station. From there he was sent home, but almost immediately he became disturbed again, slashed his wife's clothes which were hanging in the wardrobe, and his wife was obliged to leave the house in order to avoid him. Later, when the police found him running wildly through the streets he was taken to the Raymond Street Jail, Brooklyn. On account of his obvious mental derangement he was soon sent from there to the psychopathic ward of the Kings County Hospital. There he stated that a gang had been following him for 2 weeks, that they wanted to kill him so as to get his wife, that he had heard them day and night outside his home, and that wherever he went, he noticed, strangers would watch him and make ugly remarks about him. He was committed to the Kings Park State Hospital and recovered promptly. He was disinclined to go into details about his trouble, but said merely that it was caused by excessive drinking. He was released on July 28, 1907.—He then rested up at home for about a week, after which he went back to work, and soon began to drink again as formerly.—Thereupon he again gradually developed occasional hallucinations and ideas against his wife and others with whom he thought she was in league, and finally began having episodes of excitement and fear. During one of these episodes, in the latter part of October, 1907, he ran into a police station demanding protection against his enemies. He was again placed in the Kings County Hospital and readmitted to the Kings Park State Hospital on Nov. 1, 1907.—Upon his second admission he conversed relevantly and coherently and co-operated freely in the examination, except when questioned concerning his hallucinations and delusions, giving any information on these subjects meagerly, with evident reluctance, and only on being urged. He showed no impairment of orientation or memory and no emotional disturbance beyond a feeling of resentment, directed chiefly against his wife. He complained that at home and everywhere in the neighborhood he was constantly annoyed by people saying "Dope Ballard, dope Ballard"; also that in the morning his wife would nag at him, saying "Dope, dope, dope." He said further that his wife had been untrue to him, that she would leave the house at 8 in the morning and stay out until 4 in the afternoon, and that he knew that she spent that time "trotting in Fulton Street," adding, "trotters are no good." She tried in various ways to get rid of him, but most frequently by putting dope in his coffee; he noticed that his cup was always filled first; in the bottom of his cup he would often find a white powder; in the morning he would feel so dopey that he would often rise; often he even vomited. Later, however, he noticed that he would have similar symptoms when not at home, and he concluded that others, who were in league with his wife, were also trying to poison him. He therefore decided to buy no whiskey or beer anywhere in the neighborhood of his home, but found, to his great disappointment, that, on going out with one who, he had thought, was his friend, and drinking with him in a saloon at a great distance from his home, the same symptoms appeared. He was thus forced to realize that the man was no friend of his, but an enemy, and, like a good many others, in league with his wife. When asked about his previous admission to the Kings Park Hospital, he said he had that figured out also. Although he had thought that it was but an attack of mental trouble due to drink, he now knew better: "I have found out, and thoroughly, since; it was the same dose; this is the second time I was burned, and it will be the last." He added that all he wanted was to get a separation from his wife; he would then allow her "to trot in Fulton Street." He declared later that his enemies would not leave even his 14-year-

old son alone: "They even tried to give the boy some of it and they put him to sleep; it has been a dope racket all the way through."—He showed gradual improvement, and when examined again on Nov. 24, 1907, he said he realized that he had imagined a lot of stuff when his mind was affected by excessive drinking; he continued to believe, however, that his wife had really called him "dope" at home, because he drank so much.—By February, 1908, he seemed to have recovered fully and developed good insight. On March 29, 1908, he was granted a parole at home, and a month later discharged as recovered.

CASE 58. Delirium tremens. Henry (15), p. 158.

Typical manifestations of delirium tremens were observed in the case of a forty year old business executive who had been drinking to excess for thirteen years. On admission he was anemic and undernourished and showed marked tremor of his tongue, lips and hands. He was unsteady and uncertain in his bodily movements and in his speech. He talked of scenery moving by on the ceiling, snakes crawling around and of a wolf biting at his chin. "I can't sleep—there are two snakes crawling around on my pajama coat. I gave it to one of them (slapping bedclothes). My, what a lot of flies in this room! (none present). Guess I'll wear these trousers (bed sheet). Here, Joe, leave those papers alone. I'll take this voucher along with me (takes hold of blanket)." He picks at pajamas and says, "Oh, there I've got you, you rascal." He also picked an octopus off the floor and alligators out of his vest pocket.

During the first four days his condition remained stationary. He saw brown cats, red canaries, bugs, dogs and goats in his room. At various times he said he was in a hotel, a club, a friend's home, and aboard a ship. He carried on conversations with people not present. He talked as though his wife were in bed with him and he was apprehensive that she might be harmed. At times he appeared apathetic. He wet himself and made a diaper for himself out of a newspaper. Recent memory, retention and immediate recall were poor. He gave a rambling, inaccurate account of what he had been doing in the past month. Remote memory seemed unimpaired. Calculation was inaccurate and he showed no insight regarding his mistakes. He said he was a little nervous but would soon be perfectly all right.

This patient's father drank to excess but had periods of several months during which he was a total abstainer. His only uncle gradually developed hallucinations and delusions of persecution after several years of heavy drinking and spent the last eleven years of his life in a state hospital.

The patient was dominated and protected by his mother who objected to his marriage. He preferred the company of men and was somewhat promiscuous in his relations with women. His first marriage ended in divorce and he began to drink to excess when his second wife talked of getting a divorce. They quarreled because he did not want her to have children.

During the first few weeks of hospital treatment the patient's condition improved rapidly. The hallucinations disappeared but he continued to be troubled with visual distortions for three months. Objects seemed to be either too large or too small. He became apprehensive that his own voice was peculiar or that he was not acting normally. After five months he was discharged much improved with a diagnosis of delirium tremens. He continued to improve and returned to his work. A year later he reported that he was living amicably with his wife and that they had a healthy child. He had solved most of his difficulties by total abstinence and he had found that it was not necessary to drink in order to be successful in business.

CASE 59. Alcoholic excesses; delirium tremens. Southard and Jarrett (3), p. 250.

Patrick Nolan, forty, is presented as a case of delirium tremens, that most frequent of the alcoholic psychoses. This man was, according to the mental tests made by the psychological examiners, of a very high rating, namely 15.5 years of mental age (close to the limit of age that can be tested by present-day psychometric tests) and scored in other ways his intelligence was high. This test was made November 19 and the patient cooperated well though he was at that time impatient to get to his family waiting upstairs. He had been admitted to the hospital four days before, namely on November 15.

Nolan was an Irishman, alcoholic from the age of twenty-two years. He had been drinking to great excess for some days and had become very nervous and tremulous. Two nights before admission, that is on the night of November 12, Patrick waked up a family that lived near him and asked the head of the house to come to the Nolan home and stay with him as he was nervous and afraid he would die. His wife was in hospital for a slight operation and he had resorted to whisky for companionship. He himself said that while he and whisky had always been good friends before that, after his wife had gone to the hospital he and whisky had become inseparable. His friend, Mr. Doherty, stayed with Patrick all night. Patrick slept not at all but wandered from room to room. He seemed a little better next day but in the afternoon talked about seeing his dead brother. Accordingly a physician was called who found all the lights in the house lighted and the doors locked. Patrick refused to see the doctor; the police came; Patrick then opened the door and went with them talking about devils who were getting him. So far as his friends knew or at least would say, Patrick had never had a similar state before.

For two nights in the hospital he continued to see devils under his bed. He was "somewhat depressed" but the line between depression and a proper sadness is naturally hard to draw. When he told his story he had become humorous. All are familiar with the humor of the Irish but it would appear from medical observations in alcoholic psychoses that the so-called "humorism" is not merely an Irish trend but is found as a somewhat differential effect of alcoholism in a variety of races.

Patrick Nolan failed to see the "animals" which one is supposed to see if a victim of delirium tremens. Perhaps "devils" will serve in their place. It is just as well, however, that the case we here choose to illustrate delirium tremens is a case without the so-called zoopsia or hallucinations of animals.

Physically Patrick was a muscular, gray-haired, ruddy-faced man having the somewhat characteristic weather-beaten alcoholic facies. Aside from a flushed face and widely dilated pupils, there was nothing of note in the physical examination save very active knee jerks. The victim of delirium tremens is rather apt to look more "sick," that is, physically sick, than the victim of alcoholic hallucinosis. The facial flush, the tremulousness, the dilated pupils, the look of a certain confusion and perhaps fear combine to give this impression of a delirium tremens victim as looking "sick." "Nervousness" is a term the layman is apt to use about this state; but the term is used for so many other states that it is of little or no value from a standpoint of diagnosis. He was discharged recovered on the seventh day and his frank psychosis had thus lasted apparently some nine or ten days in all.

Patrick was now referred to the social service. He was a married man without children who lived on the top floor of a three-family house. He was an unskilled laborer earning fifteen dollars a week. Both he and his wife were church members. In Ireland he had had schooling until his thirteenth year and

had worked on a farm until he was twenty-four. A brother had died at forty of cirrhosis of the liver, a condition which many books describe as of alcoholic origin, and which, no doubt, is often alcoholic in origin though other factors must probably enter. Another brother had died at the same age, forty, of heart disease. Still another had died of tuberculosis at thirty-six, and the fifth of the five brothers had been a victim of delirium tremens at one time at the Psychopathic Hospital.

An arrangement was made for the patient to come to the Men's Club but this proved not feasible. However, without this aid, through the very light supervision necessary, the patient ceased to drink and it was possible to close the case two months and a half after he first came under observation. It may be queried whether this case was not closed too early and this must be admitted, though no doubt with the experience in hand any renewed resort to alcohol on Patrick's part would have been quickly called to the hospital's attention on account of the relations established with the wife.

Hours spent by:	Medical record, 13 pages
Physician, 3½	Social record, 2 pages
Psychologist, 1	Social work:
Social worker, 5	Visits, 2
	Interviews at hospital, 1
	Telephone calls, 0
	Letters, 1

CASE 60. Alcoholism complicating epileptic seizures. Southard and Jarrett (3), p. 236.

Luigi Silva was brought to the Psychopathic Hospital by the police. He had had a fit and become violent and destructive during a heavy drinking debauch. He was still noisy and excited upon his entrance, unclear as to mental processes, and quite inaccessible to the examiner. When seen he was trying to break windows; looked as though he saw animals and seemed to be trying to pick up some things and avoid others. He would cry out: "Why don't you take that thing off of my shoulder?" or again "It is a lie!"

Two days later he was perfectly clear. He remembered having hallucinations of hearing and had a proper insight concerning them. He was quite vague as to his time in the hospital. He seemed on the whole rather dull. Psychometrically he graded at 9.2 years; the grading was rather irregular, suggestive, that is to say, of an acquired deterioration. He was rather effective with the construction puzzles and fair upon the memory tests. Physically the only positive points of note were moderate impairment in hearing of both ears, slight nystagmus, and slightly excessive reflexes on the left side of the body.

Silva had been born in Boston of Italian parents, left school at the age of fourteen to go to work, and had sometimes earned (doing heavy nickel and brass work) as much as ten dollars a week. Later he earned as much as twelve to fifteen dollars a week. He had been a reliable workman, not especially alcoholic. At about the age of thirty-one he had had his first attacks of an epileptic nature, coming every three or four weeks. For the past two years he had been unable to work on account of the seizures. Of late he had begun to drink a good deal of whisky. Two weeks before his arrival at the hospital, his mother died, and after her death he had a very heavy drinking debauch whereupon ensued the violent and destructive attack above mentioned.

Upon his discharge from the hospital he went to live with a relative on a farm. The plan was to keep Silva away from the temptation of liquor. Now and then he was to come to town to go to the hospital clinic. This plan was carried out. The patient helped about the farm, doing light carpentry, feeding animals, and cutting ice. The cousin brought him to the hospital from time to time. Immediately after his discharge the attacks grew for a period more frequent and severe. He is still having attacks which for the time are of milder nature. He is said to be improved mentally, which improvement presumably means that there are fewer after-effects of the now somewhat mitigated attacks.

There are a number of medical problems in the Silva case still unsolved. Like all but a small minority of epileptics he exhibits a number of signs of structural disease of the nervous system. We do not know why the epilepsy began, as it is said to have begun after the age of thirty. We have so far found no evidence of epilepsy in other members of the family.

Perhaps we might use our ignorance of certain features in the epileptic Silva to insist upon the importance of the whole problem of the epilepsies. Perhaps nothing is more harmful to the victims than to lump them all under one term "epilepsy." It is just as true that there are numerous forms of epilepsy as that there are various forms of mental disease. The relations of alcohol to epilepsy are particularly intriguing. It seems to have been proved that alcohol tends to produce more frequent and possibly more severe attacks of epilepsy in confirmed epileptics. There are also cases to prove that alcohol can de novo produce epilepsy in a person without hereditary soil or acquired taint, and that this epilepsy may then persist even without the stimuli of further alcholism. But these relations between alcohol and epilepsy cannot be said to be thoroughly established in such a way as to offer clear principles of prognosis. Alcohol is only one cause or complication of the epilepsies. Without going into the special natures of the major kinds of epilepsy, it can be readily seen that in the field of epileptology, the social worker, to say nothing of the psychiatrist himself, must step gingerly.

Hours spent by:
- Physician, 5½
- Psychologist, 1
- Social worker, 17¼

Medical record, 19 pages
Social record, 6 pages
Social work:
- Visits, 10
- Interviews at hospital, 0
- Telephone calls, 6
- Letters, 3

CASE 61. Alcoholism with criminal tendency. Rosanoff (23), p. 368.

F. J. H., male, age 40 years, a prisoner held on a charge of murder. Referred by the Superior Court of Los Angeles County, for psychiatric examination, in August, 1936, a plea of "not guilty by reason of insanity" having been entered. He served in the army during the World War; later was employed by the U.S. Public Health Service for a year during an epidemic of bubonic plague, and then for 7 years as inspector in the Los Angeles City Health Department.—He had been for many years a "moderate" drinker. In 1932 had to give up his position "on account of poor health," but by that time had begun drinking to excess "at times." In December, 1932, he served a term of 31 days in jail for a liquor law violation ("illegal possession"); no other prior criminal record. After that he worked as "an extra" in the moving picture studios for periods of 2 or 3 days at irregular intervals. He was then drinking heavily, especially "for a couple of

weeks each month, after the check came." Occasionally he would be "fighting drunk."—After 1931 he "kept company" with a bootlegger's wife who, eventually, left her husband, as she and the prisoner had planned to get married. She, too, was a heavy drinker and quarrelsome when drunk. Although they were very fond of each other, they had, when drinking together, frequent violent quarrels: "a lot of times we fought, over every little thing, pulling hair, hitting each other, and the like." On April 5, 1936, while they were drinking with a party of friends, he "beat her up" with a beer glass, inflicting a number of cuts about the head and face; she bled profusely and a doctor had to be called to stitch up her wounds. Still they were "the best of friends."—On July 28, 1936, they drank "some" during the morning by themselves, later, with a party of friends, "3 or 4 more rounds of drinks." The friends left at about 3 o'clock in the afternoon, and they were alone, both in "a nasty mood." A few days previously he had lost his temper when he stumbled against a bed post and kicked it so violently that he sustained a Pott's fracture, so he could get about only on crutches and his ankle hurt him. This increased his irritability.—Very soon a quarrel was started. He asked her to cook him some eggs, but she left them on the stove until they were hard boiled and then told him to help himself, in spite of his hurt ankle. "She knew I didn't like no hard boiled eggs." So he went into the kitchen and cooked himself some other eggs, and then went and lay down in the bedroom. Then she came in and demanded that he join her in the living room, as she was lonely. He said, "Get out of here and let me alone." So she came back with a carving knife and said, "I'll get you out of here all right!" A struggle ensued; she dropped the knife, he picked it up as they both rolled on the floor, and by that time he was "sure fighting mad." He struck her with his fists, inflicting many bruises, then inflicted many superficial stab wounds with the knife, finally the knife was plunged deeply into the base of her neck, in a downward direction, and penetrated into the left lung. "The blood welled out," and this brought him to his senses. He grabbed a piece of cloth and pressed it to the wound to stop the bleeding. He could not leave her to call a doctor, so he shouted through the open window to a neighbor to get a doctor at once. The doctor came as soon as he could, but the bleeding had been so profuse that she died before the doctor arrived. As the doctor was entering the front way, the man slipped out the back way, having first wiped off the knife and taken off his blood-stained shirt, hiding it behind the davenport. He then returned to the apartment where he was staying, asked the manager not to tell the detectives that he was registered there. The detectives arrived before he had time to leave the apartment house, and he was placed under arrest.—At the coroner's autopsy the victim's brain was found to contain 0.12% of alcohol.

VI. MIGRAINE, EPILEPSY, AND OTHER CONVULSIVE SEIZURES

CASE 62. Migraine; three illustrative cases. Bluemel (9), p. 278.

Denise R., 17 years old, had her first attack of migraine on the day she entered high school when she was fourteen years old. She said the teacher was loud, and this made her nervous. After this attack she was free from headache for two years, then the attacks recurred with troublesome frequency. Attacks usually begin with headache affecting the orbit and temporal region on one side of the head but never on both sides. This symptom is accompanied by scintillating scotoma which gradually increases in size. Shortly the tongue gets numb and the speech gets thick. The lips feel tight and drawn and the muscles of the throat tighten up. She feels strange and confused and she cannot think clearly. The hands are cold and she has nausea and vomiting. At times the arms and legs get numb, and she cannot hold a pencil properly and cannot control her feet. When going up or down stairs she cannot see the steps and she is apt to stumble. She has to lie down and she usually keeps the shades drawn because the light hurts her eyes. The symptoms persist for the balance of the day. On the following day she feels weak and worn out. Fatigue is probably an etiological factor in this case as the patient has been taking four years' high school work in three years.

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Dorothy B., 21 years old, had her first attack of migraine eleven days ago. She des(·ibes the experience as follows: It seemed at first that she could not focus her eyes; the eyes felt jumpy but there was no double vision. This disturbance was shortly followed by a prickling numbness in the lips and tongue, the sensation being similar to that from a local anesthetic. One hand got numb, then the other. Voices seemed far away and things seemed strange and unreal. It was the funniest sensation she had ever had in her life. The attack lasted for two and a half hours. There was no headache. The second attack, which occurred yesterday, was similar to the attack of eleven days ago except that numbness lasted for five hours and affected the right hand, the right cheek, the right side of the nose, and the entire tongue. Headache ensued toward the end of the attack and affected the left temporal region. The sense of unreality was pronounced and the patient believes that she got her words mixed up when talking.

. . . . . .

Grant B., a physician, 36 years of age, gives the following clinical history of migraine: He has been subject to sick headache for several years, the attacks occurring when he is tense and tired, for instance after studying hard or preparing a paper. This morning on getting out of bed he was conscious of tingling and a sense of heaviness in the left hand and forearm. There was definite weakness and he lacked control of the fingers. When performing a tonsillectomy he was unable to operate the snare with his left hand. He had difficulty in turning the steering wheel of his car. When he was examined in the afternoon there was numbness only over the ulnar portion of the hand. The hand was said to be stronger than it had been earlier in the day, but the grasp was only 10 kilograms as contrasted with 26 kilograms in the right hand. On the following day the numbness of the hand had disappeared and the grasp of the hands was equal.

CASE 63. Epilepsy; petit mal. Hunt, Wittson and Harris (18), p. 566.

The development of the electroencephalograph with its possibilities for diagnosing minimal epileptic states has recalled attention to the prevalence of mild petit mal attacks which are not attended by any but the slightest, fleeting

objective signs. Recently we have observed such a case under unusual circumstances which made it possible to obtain a measure of the amount of impairment in mental function following the petit mal seizure.

The subject was seen during the routine neuropsychiatric examination of recruits at the U.S. Naval Training Station, Newport, Rhode Island. While he denied any history or knowledge of convulsive disorder, he gave the clinical impression of some form of epilepsy. The psychiatrist then requested an immediate psychometric testing, hoping that this might reveal further information. The psychologist was unaware of the possibility of epilepsy and treated the case as one of suspected mental deficiency. The test battery in use at Newport consists of four brief subtests, each of which is scored and evaluated separately. On the first two of these the subject's performance indicated dull normal intelligence. Just before the beginning of the third test the psychologist noticed a brief flutter of the subject's eyelids and the temporary presence of a fine head tremor. These were noted but casually as possible signs of some excitement in the testing situation. On the third and fourth tests, however, the subject's performance fell to a level bordering on the feebleminded. In terms of mental age (with 14 considered as the adult level) his score went from 13-6 on the first part of the test to 11 on the second. This drop demanded some explanation, particularly because of the sharp cleavage between the performance level on the two parts of the test. At this point the psychologist realized that the fluttering eyelids and head tremor might have signified a temporary impairment of consciousness. Direct questioning then uncovered a typical history of petit mal attacks and the subject admitted having had a seizure between the second and third tests. He revealed he had lied to the psychiatrist lest his disability bar him from the Naval Service. It was not possible to follow him further at that time, but he was retested later in the day on the observation ward and passed all four tests on the dull normal level.

When the subject was studied during his stay on the observation ward he gave a clear history of minor petit mal seizures occurring with no, or very minimal, overt behavioral manifestations, and he was observed by another medical officer during the course of one such attack. While he was being studied he received other routine tests. His performance on some of these showed wide variation, suggesting that he had suffered further attacks, but this could not be confirmed.

The danger of such apparently slight petit mal attacks for men in the armed services is seen from this case where, as a consequence of a seizure, the level of mental ability fell from a dull normal performance to one bordering on feeblemindedness. Had the attack occurred during actual battle when efficient, exact performance is required of every man at his battle station the results might well have been disastrous.

CASE 64. Epilepsy; with mental deficiency. Hanes (18), p. 87.*

Reuben S___, Pvt. Co. C, 324th Labor Btn. Exam. S. 24/18. Diagnosis: (1) Mental deficiency; (2) Epilepsy; (3) Syphilis.

A remarkably large, powerful negro with mitral and aortic murmurs; face scarred by smallpox, but neurologic symptoms negative. Admits syphilis which he says, "Ain't out of my blood yet." Married, one child; wife left him for inadequate reason, but she said, "I didn't treat her right." Entered Mil.

*This and cases 65 and 66 reprinted by permission from The Minds and Nerves of Soldiers by Edward L. Hanes, published by The Login Press.

Service in April, 1918. Had difficulty in learning drill—couldn't learn squad movements—"always 2nd or 3rd in rear rank." Does not know reason why U.S. entered the war, or name of ship bringing him to France, etc. Says he "was a wheezer" when small—"they used to think I was dying."

Relative to present trouble says, "I have been havin' 'fitified' spells all my days—they say I don't know what I be doin' when I have them—they come every change of the moon—sometimes they ain't so bad as they be other times—sometimes I fall down and they stays on me for 2 or 3 days—sometimes I git over them in an hour and go back to what I was doin'." Speech clear but low in pitch; no hesitation, but all concepts simple and illiterate. Essentially docile and good natured.

Recommended for Discharge from Military Service.

CASE 65. Epilepsy (grand and petit mal). Hanes (18), p. 88.

James O___, Pvt. Q.M. Dtchmt., Vichy. Exam. O. 25/18. Diagnosis: Epilepsy (G.M. and P.M.) (Idiopathic; diurnal.)

Pat. uncle epileptic; otherwise heredity denied. Pt. a negro of 25 yrs. Resident of Fla. Denies syphilis; admits gonorrhoea at 20. Married 1½ yrs. ago. Reads and writes. Inducted by draft into Q.M. Dept. Apr. '18; assigned to Group Q.M. as cook in S. '18—his civil occupation.

As school-boy had "staring and forgetful" attacks many times daily, gradually lessening in frequency so that they occurred bimonthly at 16th yr., ceasing at 17th yr., but recurring at 21st yr., though "not often and did not bother." At 23rd year had first convulsion, when he lost consciousness, fell, convulsed and became automatic with wandering tendencies for an hour or so. A 2nd conv. in Apr. '17; then no more till O. 2, '18 and again O. 18, '18; during first attack wandered out of dining-room and fell on street, awakening to find himself in bed; during second attack fell in dining-room, wandering about there automatically; in both attacks received cuts from the falls upon right frontal region.

Physically no neurologic complex; healing cuts over R. frontal region; abscessed molar in R. lower jaw; palpable inguinal glands; soft functional bruit over precordia, systolic in time—pulse, 100, regular.

Recommended for Discharge from Military Service.

CASE 66. Epilepsy; in moron. Hanes (18), p. 89.

Chester W___, Pvt. Co. C, 531st Engr. Reg. Exam. O. 4/18. Diagnosis: (1) Mental deficiency (moron); (2) Epilepsy.

A southern negro of 23 yrs., whose pat. uncle is epileptic. Uneducated; did not attend school till 17th yr.; "sickly" (convulsions) before, which prevented. A hotel porter for short time at 20th yr. but lost job because of a "fit." Always lived at home till drafted. Has had several fits in army. At 14th yr. frequency of severe attacks diminished, but "smothered feelings" (petit mal) continue and made worse by hikes and over-exertion. Describes post-epileptic automatism. Had severe convulsion on S. 24, '18 and sent back to B.H. 5 and B.H. 19.

Mentally dull, slow, deficient native and acquired endowments; stolid; asocial; unable to describe trip to camp in U.S.—does not know difference between lake and ocean, or what body of water crossed en route to France; describes work by saying, "I work just like the rest of them."

Physically no complex of organic neurologic or somatic disease.

Recommended for Discharge from Military Service.

CASE 67. Epilepsy; possibly traumatic. Southard and Jarrett (3), p. 238.

Patrick Donovan, thirty-six, killed his mother and an indictment was found against him for murder in the first degree. Patrick had given himself up to the police, saying that the beer he had drunk the night before had been drugged and he did not know what he was doing. His sister thought he had had convulsions the night before the murder. These convulsions were not necessarily "epilepsy." It is important for the social worker not to confuse every fit of convulsions with the disease, epilepsy. But these particular fits turned out to be very definitely epilepsy, due to an injury ten years before.

Patrick had never had any serious illness before the age of twenty-six, although he was said to have been always very quiet, sullen, and quick-tempered—more quick-tempered with members of his family than with strangers. In short even before the fracture of his skull at the age of twenty-six he might be thought to have shown somewhat of an epileptic temperament, at all events a psychopathic temperament. Patrick's brothers were all alcoholic; his paternal great-grandfather had had a mental disease; his father had become insane at the age of forty.

The patient was struck on the head by a ledge weighing sixty pounds and was in the hospital for some thirteen weeks. On the day of the accident there were nineteen convulsions. From that time forward convulsions occurred frequently throughout his life, as a rule at night. Patrick drank heavily of water and had a large appetite. He grew very jealous and was unsociable in his family.

There could be hardly any doubt that Patrick's action was epileptic. His mother's body was badly mutilated. Some time before, it now transpired, Patrick had assaulted also his sister, breaking her jawbone. He had at that time also been drinking.

The psychiatrists found Patrick well oriented as to time, place, and person, nor could much impairment of memory be determined. He told of times when his heart stopped beating for long periods whilst he was lying in bed. He told how he had a queer, shivery sensation in his body. Often he felt he was falling when he was not falling.

The psychologists found Patrick of the mental level of thirteen years. There were no irregularities in his mental tests (that is to say, no marked examples of his passing tests of high year levels while failing to pass the tests of earlier years). His associative processes proved to be slow, as well as all of his responses, although he co-operated well. His vision had been somewhat diminished since the accident and the psychologists felt that his rating was thereby somewhat lowered. It seemed accordingly that Patrick was not to be regarded as feeble-minded by the mental tests.

Physically there were signs of the old head injury. There was no marked evidence of heart disease. Neurologically he showed sundry effects of his old fracture in the shape of elimination of the fields of vision of the right side and some visual impairment. The X-ray conformed the history of the fracture.

Here is a case in which the sphere of authority was .... almost purely public—indicted for crime he could almost at once be determined to be irresponsible for an act done at the time of epileptic seizures. He could therefore promptly be sent to an institution for the criminal insane, where no doubt he will lead a tranquil enough life punctuated by occasional epileptic seizures. In certain epileptic cases there is a possibility of surgical aid. But in this instance the medical details of the examination were such that surgery was not recommended.

What is the province of the social worker in a case like that of Patrick Donovan? The social worker's task is practically confined to the collection of data of value in the medical and psychiatric judgment of the case. In this case various

points concerning heredity were obtained. Thirteen agencies, relatives, friends, and employers were consulted by letter, telephone, or interview.

There is no special tendency to epilepsy in the offspring of the injured patient. It is often of value to reassure the relatives of traumatic epileptics upon just this point. The theory is that the injury to the brain which brings on cerebral convulsions does not injure the germ plasm and accordingly has no effect upon heredity. In this instance there were no epileptics in the family tree, but there was mental disease on the father's side and there the patient's brothers were alcoholic. Besides this his somewhat psychopathic temperament must be considered.

Hours spent by:
- Physician, 5
- Psychologist, 1
- Social worker, 5

Medical record, 15 pages
Social record, 4 pages
Social work:
- Visits, 2
- Interviews at hospital, 0
- Telephone calls, 6
- Letters, 6

CASE 68. Epileptic delirium. Rosanoff (23), p. 267.

Louis M., 42 years old, cab driver. Father alcoholic. Patient has had epilepsy from infancy. Has typical epileptic convulsions, though not frequent, almost exclusively nocturnal, occurring about once a month. Absences of long duration: one day the patient found himself driving his carriage about 8 miles from the place where he wanted to go, not knowing how he came there.—Feb. 17, 1901, toward 6 o'clock in the evening, following a violent dispute with a neighbor, the patient came home sad, depressed, and told his wife that he would throw himself into the river rather than live in such a disagreeable place. He went to bed without any supper and fell asleep. About 9 o'clock he stood up in his bed, seeming to be in great fear and emitting inarticulate cries, then ran with nothing on but his shirt into the next room, seized a hatchet, and came back into the bedroom, where he began to hack away at everything within his reach. His wife, terrified, ran out and called for help. Some of the neighbors came but no one dared to enter the bedroom. In the meantime they could hear the strokes of the hatchet and the cracking of the furniture. In a few minutes the patient went at the door of the room, kicking it with his feet as though trying to break it down but making no attempt to open it. Finally 3 men climbed into the room through the window without the patient hearing them. They approached him from behind, disarmed and overpowered him, and while he defended himself violently and tried to bite them, they succeeded by the greatest efforts in getting him down and tying him to his bed. The patient struggled violently to free himself, but preserved complete mutism all the time and did not seem to recognize anyone. His respiration was panting, skin covered with perspiration, pupils widely dilated.—Toward 5 o'clock in the morning consciousness appeared to be returning. The patient began to look around him, noticed with astonishment the straps with which he was tied, and said a few words: "Take this off from me .... What is the matter with all these people? ...." At about 6 o'clock he fell into a deep sleep and woke up at noon, tired but lucid. He had some recollection of the beginning of the attack. He said he had had an impression that someone came into the room after him and his wife; it was then that he uttered the cries and ran to get the hatchet. After that he could remember nothing up to the time that he

found himself in his bed. But what he saw even then he remembered but vaguely; he could not tell who were the people whom he had seen around his bed and said he believed that he had not recognized them at the time. Finally when shown the damage which he had done (the furniture in the room was partly destroyed), he was stupefied and could hardly believe that he had been the cause of all the destruction.

CASE 69. Epileptic fugue. Southard (8), p. 78.

A blacksmith from the Rochefort Arsenal, 27 (nothing known as to grandparents; father, now in the fifties, for 30 years in an asylum with frequent attacks of furor; mother, 45, well and apparently well-balanced; brother with the colors, wounded and decorated with the military medal; a cousin-german, who has had a typical epilepsy—in the patient himself enuresis up to 13 or 14, later, less frequently; apparently no tongue-biting; no information as to infectious diseases; graduate from primary school, apprenticed to a blacksmith; an unskilful worker; never able to rise to the level of a frappeur), in 1909 had passed the board of review and been put in the sixth division of the line. Antebellum there was a history that one night at supper, he had slipped away from quarters and gone 30 kilometres, home. His astonished mother sent him back to the military post by railway.

Upon the night of May 26-27, 1915, this soldier found himself in the position of a sentry, opposite the enemy. He told his comrade that he had to go away for a time, leaned his gun against a tree, disappeared, and did not return. It was then one o'clock in the morning. At six o'clock, he was found two kilometres away from the lines, in a village. He was in front of a barn where his company had been quartered before taking possession of the advanced posts.

He was brought up before the military authorities; but upon stating that in civil life he had wandered off several times without knowing where he was going, he was submitted to neurological examination. There was available a letter from his family physician relative to his antebellum military service. It appeared that he had committed a number of breaches of discipline, and that he was regarded by the physicians as a déséquilibré. He had lived with his mother a very quiet and good life; there was no history of sexual irregularity, and no history of illness except a slight catarrhal jaundice. He had frequently suffered from headaches; there had been slight attacks of vertigo of very brief duration. He had never fallen in these fits. From his story it was elicited that he had had absences; his comrades had noticed that he sometimes stopped stock-still with vague eyes, then shortly regained his wits and continued upon his task. Sometimes he would not work without being able to explain why he went away. He would go off for a period and, upon coming to, discover that he had not eaten his meals. There were never, however, any convulsive crises by day or night. He sometimes felt sick, and although there was no medical treatment, from time to time he took bromides upon his own authority, saying he had been ordered to do so by his father. Although habitually of a gentle demeanor, nevertheless he was subject to excessive anger upon slight occasion.

During the mobilizing and first months of the war, both in quarters and at the front, however, his conduct had been that of a good soldier. Suddenly, about March or April, 1915, the nocturnal enuresis began to be frequent again, occurring twice or three times a week; but the patient hid this misfortune as far as possible from his comrades. The captain thought he looked tired and depressed sometimes. Upon the days following the nights with enuresis, there was intense headache and marked moral and physical depression. There was no proof of

nocturnal convulsions, and it is very problematical whether there was tongue-biting.

Another odd feature was that the patient, who had been sober in civil life, had become intoxicated several times after going into the army. Physically, he was of low stature, but otherwise well built. Neurologically, he was entirely negative. There was no sign of venereal disease. There were a few stigmata of degeneration; for instance, there was very little hair upon the face, the ears were unequal in size, and the teeth were somewhat anomalously set. Mentally, he was below par; for instance, he could not add mentally two numbers of two digits.

As to his desertion, the patient says he does not know what he did; that he learned of his act only from his comrades in the morning; that he remembered having left his duty pour aller satisfaire un besoin.

CASE 70. Rorschach examinations in a case of organic epilepsy. Penfield and Erickson (20), p. 564.*

M. L., age 20. Epilepsy, major seizures. Removal of cystic astrocytoma from left frontal region. I.Q., preoperative 124; postoperative 123.

Four Rorschach examinations were given: Preoperatively, three weeks postoperatively, one year postoperatively, and two years postoperatively. The preoperative Rorschach record revealed the impoverished and restricted personality which we have come to associate with patients with cerebral tumor or diffuse cerebral damage. The second record showed some expansion of personality; while the psychological characteristics which are the counterpart of cerebral damage were still in evidence, a change in the direction of a more normal record was indicated. The record taken one year postoperatively showed a very different situation: while much more "normal" in the sense that the tumor characteristics had disappeared, it was the record of a profoundly maladjusted individual. The fourth record was similar to the third, but showed an improvement in the direction of successful contacts with the environment which had been absent before.

Environmental information: Evidence from other sources can be found at each stage to amplify and corroborate the Rorschach findings. Of particular interest is the fact that the "maladjustment," reflected in the third record, was finding expression at that time in the overt behavior of stealing and other delinquent acts which led to the patient's entering a reformatory. At the time of the fourth record the boy had been discharged, his general behavior being considered somewhat improved.

Comment. Despite an I.Q. equal to that of the previous case, E.C., this patient was a real behavior problem. While the four patients previously discussed were intelligent citizens, this boy was an intelligent delinquent. His case has been discussed in an article by Hebb (1939) and Harrower-Erickson (1940a).

CASE 71. Jacksonian epilepsy; local motor seizures. Penfield and Erickson (20), p. 68.

This patient had small spontaneous attacks consisting in pulling of the mouth to the right, turning of the head to the right, and slight twitching of the right hand, in that sequence. There was no vocalization in this, although there must have been

*This and case 71 reprinted by permission from Epilepsy and Cerebral Localization by Penfield Wilder and T. C. Erickson, published by Chas. C. Thomas.

movement of the upper face as well. Each seizure of this sort was followed by inability to talk for a little while. No doubt the vocalization area discharged as the other areas did, but was unable to express itself effectively.

A year later this patient was operated upon, a left craniotomy and negative exploration being carried out. After operation there was paralysis of the right face and right arm for some days. A short time before the paralysis cleared up a series of attacks occurred involving the paralyzed members and the following note was made by one of us (W.P.): "At 11:15 I came in during an attack, which was followed by a series of attacks which lasted 4 to 5 minutes each and faded out gradually. In general, the right face jerked, and eyes, mouth and head were drawn toward the right in sequence. The right hand then jerked in clonic manner and the elbow was flexed. At the height of the attack the right leg was extended with toes in dorsiflexion and the left leg raised. There was little clonic movement of the legs and practically none of the left arm. The legs and left arm took what might be called rigid postures while the right arm and face twitched, the head being turned to the right. At one point there were a few small twitches of the right toes.

After giving sodium luminal by vein, the legs and left arm relaxed but there continued to be convulsive, rapid, clonic movements of the members previously paralysed; there were fine movements of the right hand, and there continued to be jerking of lips on both sides, jerking of the tongue, occasional chewing movements, and the eyes turned in tonic or clonic conjugate movement to the right, with head turning to the right. Sometimes all of these movements occurred in sequence and sometimes out of step."

VII. ORGANIC REACTION TYPES

CASE 72. Post-traumatic amnesia. Henry (15), p. 181.

Post-traumatic amnesia is illustrated in the case of a college student who fell, striking his forehead on the corner of a trunk. About an hour later he was found in a dazed condition. He attempted to attend classes the next day but he suffered too much with giddiness and severe occipital headache. It was discovered that his memory was defective for events subsequent to the injury.

A month later there was little improvement in his memory and he was admitted to a psychiatric clinic. He was then mildly anxious and impatient because of his poor memory. He could retain fairly well the happenings of the day but after a period of sleep he was unable to recall them. Mental processes in general were retarded. Physical examination was negative except for a scar on his forehead. There was no evidence of skull fracture.

Several days after admission he could not remember the name of the physician who saw him daily, that he had been presented to a group of students or that he had been visited by his parents the day before. He was able to learn lists of words and nonsense syllables and a short poem but as little as two hours of sleep caused him to forget everything. It was observed, however, that he was able to re-learn these tests in half of the time previously required. He was asked to make note of the events of the day and to memorize them. After a month's training his memory extended to the next day without gross error but it was three months before he was able to resume his college work. The amnesia in this case appeared to be a direct result of the head injury as no important psychogenic factors were elicited.

CASE 73. Traumatic psychosis; gunshot wound. Southard (8), p. 136.

An invalided soldier, 40, was sent to be observed, Oct. 23, 1916, because he wanted his pension renewed. He had been retired a year before for diminution of binocular vision with impaired perspective of objects in the right half of the visual field. He had now become completely blind.

He had been wounded, March 12, 1915, in the Argonne, without losing consciousness. He was wounded at ten o'clock at night and waited until the next day to walk to the ambulance and was at this time able to see perfectly. Arriving at the ambulance he lost consciousness. He was trephined but remembers nothing about the trephining.

His memory grew better from his arrival at a hospital in the rear in April. An attempt was made to remove the bullet in May, 1915. Though the surgeon's finger was pushed as far as the tentorium the patient did not lose consciousness or sight, but on leaving the operating room he fainted and, after a few days of restlessness and delirium, he became completely blind. There was a cerebral hernia difficult to reduce. Vision became a little better and light and persons could be distinguished at the time when he was retired. A month after the operation there was a convulsive crisis beginning in the left arm, affecting the legs and ending in unconsciousness. Several similar crises occurred in August, sometimes with and sometimes without loss of consciousness. Later these crises began to be limited to the left side and then to be ushered in by visual hallucinations. At home he was unable to care for, clothe or feed himself. The crises became more frequent. The visual hallucinations began to dominate.

This situation lasted to February, 1916, when the blindness which had been increasing since the onset of the hallucinations became complete. The crises

now became less frequent and intense. Headaches not severe were exaggerated after seizures. The patient acted like a totally blind person and said that he had before him a uniform and constant gray without any light or dark spots or any color. Upon this background bizarre pictures, caricatures, disguised persons, animals or nameless things appeared colorless without relief, in silhouette, but highly suggestive of reality to such a degree that at first, according to the patient, he had made gestures to reach, or push aside these pictures. The crises were Jacksonian.

Pallor, perspiration, shivering, irresponsiveness, clonic spasms of left arm followed. The patient always had a premonition permitting him to get into bed if he was sitting, for example, in his chair. Sometimes there was a dizzy sensation as if the body were being rotated to the left. This sensation did not occur at the beginning of the seizure and the patient fought against it, turning to the right. Sometimes he felt as if he were sliding at great speed down an inclined plane. Headaches and sleepiness followed, but there was never any complete loss of consciousness of memory.

The eye grounds proved normal and all the photomotor reflexes were normal, though there was no pupil reflex to pain. The patient could write readily to dictation printed letters. It would seem that these printed letters mean that he had visual memories, as he traced the characters as if from a design. Speech was monotonous with some stuttering; but his speech had always been of this sort according to information. He walked with difficulty, not merely on account of his visual but on account of his equilibration disorders. Outside of his seizures he always turned to the right and if left to himself standing he turned to the right. If asked to walk straight ahead, he always turned to the right. Silent and uncommunicative, he was amiable and sometimes even gay. He often had troublous dreams, sometimes seeing his relatives. He said he could bring up in his mind the faces of his relatives and even the appearance of the Salpêtrière. Reflexes and sensations were normal. There was a traumatic rupture of the tympanum. Lumbar puncture showed a slight excess of albumin and 1.8 lymphocytes to the cubic millimeter. The Mauser bullet was found by X-ray in the left calcarine region with its base touching the median line, and applied to the inner table of the skull about a centimeter above the internal occipital protuberance pointing forward, outward, and upward. He was treated on a salt free diet with bromides. The seizures grew fewer and at the time of report two months had elapsed with nothing but a slight vertigo and frequent nightmares; intellectually also the patient had improved.

The case is one of cortical blindness. The seizures are explained by the vicinity of the right Rolandic region to the lesion. The rotatory vertigo is to be explained by the contact of the Mauser bullet with the tentorium and vermis of the cerebellum, which may also explain the difficulties in orientation that occurred between the crises. The visual hallucinations are doubtless due to lesion of the calcarine region.

CASE 74. Traumatic disorder; cerebral hemorrhage. Wechsler (5), p. 164.

B. N., a liquor dealer of forty-seven, complained essentially of tiredness and inability to get up in the morning. Prohibition had ruined his business and he did not have "the nerve" to ply his trade illicitly. He became irritable, dull and depressed, could not concentrate on business, slept poorly, lost his appetite, and suffered from constipation. His tiredness and depression wore off as the day progressed, and he felt much better in the evening. He smoked excessively, but drank rather moderately. He had no headaches and no other com-

plaints. The present condition had lasted about a year, but he had a similar condition five years previously. His general medical and neurological examination was negative. The fundi were normal. The syndrome evidently was one of neurasthenia, though in spite of negative findings the suspicion of cerebral arteriosclerosis was temporarily entertained. General medical attention cleared up the urinary findings, and psychotherapy seemed to have a beneficial effect on the mental condition. One day, without warning, the patient suddenly had a cerebral hemorrhage which resulted in a complete hemiplegia and aphasia. The case illustrates the possibility of organic disease, without definite signs or symptoms, simulating neurasthenia and the need of exercising unusual care in diagnosis.

CASE 75. Traumatic delirium. Rosanoff (23), p. 300.

Adrien D., mason, aged 35, without abnormal family or personal antecedents, fell from a scaffolding about 5 meters high upon unpaved but dry and hard ground. He was picked up unconscious and taken to his home.—Externally was found only a small contused wound at the top of the head, without lesion of the bone, which healed in a few days.—After being in coma 18 hours the patient gradually regained consciousness, but for 8 days remained in a state of marked confusion. He was stupid, dull, completely disoriented as to place and time, and dreamed a good deal, especially at night. He reacted to physical stimulation (pricking, pinching), but did so slowly and feebly. He did not respond to questions unless they were very simple. He became oriented as to place but remained completely disoriented as to time. His attention was difficult to gain and impossible to hold. Recollection of occurrences preceding the accident was labored and inaccurate. He had complete amnesia for the accident and what followed. Actual impressions were fixed in his mind for but a very short time; at the end of 5 minutes he forgot that he had been visited by the physician. He often brought his hand up to his head without saying anything, and when asked if it hurt him said, "Yes, a little." In the day time some illusions were noted, the patient mistaking persons for one another. Sleep was scarce, and the greater part of the night was passed in a dream state, chiefly occupational; he thought it was time to go to his work, asked for his clothes, got up and looked for his tools, conversed with imaginary persons, complained that the cords had not been properly placed, that the mortar was too thick, etc.—After the first week attention and memory improved a little. The patient retained some few impressions; yet the amnesia of fixation, though no longer complete, as in the preceding period, was still very marked. The disorientation of time persisted. A most active and mobile tendency to confabulation appeared. One month after the accident, when the patient had not yet left his bed, he told of having been 8 days before at the fair in X., where his brother-in-law, a cattle dealer, had gone to sell some oxen. In response to leading questions he gave minute details, which varied from one moment to the next and became contradictory. When the contradictions were pointed out to him he admitted readily that he might have been mistaken as his memory had failed him. The realization of his abnormal state was, however, but transitory and weak. When told that he was sick and must take care of himself he showed an irritability not previously noted, fell into violent anger, refused medicine which was offered him, saying he had had enough and wanted to go.—He had a vague idea that he had been in an accident, but, although it had been spoken of many times in his presence, could not tell the exact circumstances of it. Until the sixth week he knew only that he had fallen, but from where, what height, how, he did not know; perhaps from a roof, or a ladder, or a scaffold—such things, he said, happened often in his trade. Sometimes, by way of confabulation, he

became more specific. Thus about 5 weeks after the accident he told how he had fallen from a carriage while he and his master were on their way to see what work there was to be done. Another day he told that a heavy brick had fallen on his head. (In fact he had had a brick fall on his head about 2 years previously, but from a very low height and without causing any appreciable harm.)—He inquired from time to time if his insurance had been paid, but did not occupy himself effectually with the defence of his rights and did not seem to be interested in the progress of the negotiations concerning this matter.—Physically there was to be noted, aside from the headache mentioned above, only a general muscular weakness and some vertigo. No signs of any localized cerebral lesion. No convulsive manifestations.—The patient's condition remained almost stationary for about 3 months. After that, gradually, attention improved, memory was restored, the pseudo-reminiscences became more rare and were spontaneously corrected. Finally at the end of 6 months he could be considered convalescent, there remaining but occasional vertigo, a certain mental and physical fatigability, and an amnesic gap commencing very sharply a few instants before the accident and ending imperceptibly somewhere in the course of the second month by giving place to some fragmentary and vague recollection which grew gradually more complete and more precise.

CASE 76. Senile dementia. Kraepelin (10), p. 228.

There is a rather large group of disturbances which bear the stamp of the mental decline characteristic of old age even more distinctly than melancholia. One of these forms has already been fully discussed in the senile delusion of persecution. Another closely-associated form is presented by an india-rubber worker, aged eighty-six, who comes into the room slightly stooping and with shuffling steps. He replies to our greeting in a friendly way, with a familiar wave of his hand, and proves to be both accessible and talkative. He tells his age correctly, but makes a mistake of several months in giving the actual date, and supposes that the conversation is taking place in the year 1991, though he corrects himself when we remonstrate with him. He does not know how long he has been here, "a year or six months perhaps," but he knows quite clearly that he is in a hospital, "for his head." He knows the doctors "by sight," but not their names, and says that he has seen the assistants before. He can tell us nothing about his illness, and does not know how it began or how he came here. When we remind him that, eight months ago, he suddenly washed himself with urine and drank his own urine, and that he could not help running three times to the railway-station and coming back a particular way, he remembers what took place, but cannot give any account of his reason for doing it. "That I don't know," he says; "that I don't know even now." When we tell him that he declared he was Jesus Christ, and had been in heaven, he laughs heartily at first, and asks, "Did I really say that?" Then he grows serious, and says: "Yes; but I knew that my wife has turned off the water, so that I can't be drowned." He answers all our questions, though not very fully, about the occurrences of his earlier life and political events until thirty years ago, but can tell us hardly anything about what has happened since. He has retained what he learned at school, and particularly his arithmetic, fairly well, but he forgets words and figures, to which he has been told to give special attention, within a few minutes, and has no idea of what he has said or done in the last few days, or even the last few hours, listens half incredulously when we tell him of it, and repeats the same stories several times, without noticing that he has told them already in the same conversation. His mood is childishly merry, but sometimes, when he

is contradicted, he is peevish and irritable. He wishes to go home, but says that he is quite contented when told that he is still ill, and hopes to be well again soon. He says he has it in his head at times; his daughter-in-law, the slut, ran her finger over his teeth and made him crazy.

The principal result of the physical examination is the discovery of signs of advanced old age: atrophy of the skin, joints and muscles, extensive arteriosclerosis, and indications of cataract. The left pupil is larger than the right, and the reaction to light is unsatisfactory in both eyes. The patient is rather deaf in the right ear.

The clinical interpretation of this condition would give but little trouble, even if the patient's age did not set us on the right track at once. The confusion about time and surroundings, associated with well-maintained power of comprehension and mental activity, the wild delusions associated with a certain sense of illness, the patient's want of understanding of the general situation and his vacuous cheerfulness, but, above all, the profound failure of attention to present impressions and the very extensive loss of memory, which has only spared the inveterate impressions of a time long past, complete the picture of that morbid exaggeration of the changes seen in normal senility, which is known as senile dementia. It is true that a high degree of disturbance of the attention is met with in general paralysis and in Korssakow's disease also, but in the former affection, even if we disregard the physical signs, so severe a disturbance of the attention to impressions is almost invariably associated with marked dementia, dullness, loss of comprehension, mental clumsiness, and poverty of thought, while the loss of memory includes the impressions of early life, and attacks the arithmetical faculty, as well as the sense of time, at a very early stage. The distinction from Korssakow's disease is more difficult, if the patient's age and history are not considered, yet the failure of attention is greater there and the loss of memory less than in senile dementia. The judgment, too, is much less clouded, the delusions, when they are present at all, are not so senseless and confused by far, and the mood, in place of the childish cheerfulness of senile dementia, shows more of the dull or humorous placidity of the drunkard.

With regard to the patient's former history, I must now tell you that he belongs to a healthy family, has three healthy children, and has never been addicted to drink. He worked until eighteen months ago, but even then he had been complaining for some time of violent headaches. He used to get up in the night, put wet cloths on his head, grumbled to himself, wandered about the house, looked for his clothes, thought his things were lost, and knew nothing next day about this restlessness at night, which is highly characteristic of senile dementia. About eight months ago he began the strange behaviour already described, and said that he was a disciple of Christ, and had got a gold medallion. He was sometimes irritable, and scolded his daughter-in-law, telling her that she was a great sinner, and would go to hell. When he was admitted here, seven months ago, he called himself the Son of God, and said that he had often been in heaven, and had driven there through the air the night before in the golden carriage. When asked what it was like, he said that it was just like what it is on earth, only the fruit was better, and people only ate half as much, so they got a better living. Everything was finer there. There were no bad people in heaven, and no railways; people had to work hard, and not to idle. His wife had been in heaven for twelve years; he had redeemed her the night before. The Holy Ghost had commanded him to do good and rebuild Mannheim. "All the rich people who have gobbled up the money must help to build, with Rothschild at their head." He was quite confused about time, and did not know where he was. He slept little at night, whispering to himself and beating his breast. His mood was gen-

erally contented, but sometimes he grew peevish, and scolded at the warders, "who eat everything themselves, and leave us nothing over." Once or twice he was gloomy and unsociable, and would not speak, but lay with his eyes shut, and resisted violently when he was interfered with. He explained afterwards, when he had suddenly become friendly and accessible again, that the Holy Ghost had been with him. He occasionally refused his food, saying that he was fed by the Holy Ghost, and did not need to eat anything.

Gradually the patient became a little more clear about his position, and even said that he was quite crazy, but changeable delusions kept reappearing now and then; for instance, that his wife had risen from the dead, and brought him two orders of merit, that he was President, and the like. He sometimes made long speeches to his fellow-patients about what he had seen and done in heaven, with more or less fantastical descriptions, which he forgot completely afterwards. Once he had a brief attack of giddiness.*

CASE 77. Senile dementia; presbyophrenia. Kraepelin (10), p. 231.

You may learn the characteristics of senile dementia very clearly from the case of a woman, aged seventy-two, who was brought here six months ago. She had always been mentally and physically healthy, married at the age of thirty, and had four children, of whom two are still living. We could learn nothing of any heredity. This woman has had a great deal of trouble ever since her husband's death, which occurred seven and a half years after her marriage. But it was only about a year ago that a great change took place in her, although she had complained of headaches and giddiness for some years. The patient gradually became forgetful, was confused as to time, and did not even know her way about her house, could not remember whether she had had her meals or not, and mistook people. She thought her daughter was her sister, and often spoke of her parents, long since dead, as if they were still alive. She also showed a certain degree of restlessness. The patient became irritable, peevish, and distrustful, would not go to bed in the evening, and got up early before dawn. She rummaged about aimlessly, wanted to go out, could no longer do her work in an orderly way, and had a capricious appetite.

The patient is small and bent, with wrinkled features and white though still fairly abundant hair. Her state of nutrition is below par, but otherwise, apart from trembling in her hands and irregular action of the heart, she shows no very striking physical defect. She understands the questions put to her correctly, though often with some difficulty, and only after they have been repeated. It appears from her answers, however, that she is quite vague about time, place, and surroundings. She thinks she is here at a wedding, and imagines she knows all the people in the place, though she cannot tell their names. She complains herself of having become so forgetful—"I cannot get hold of things." She feels so much alone, and has not troubled about things. She sometimes gives the year of her birth, and sometimes some other figure, as the date of the present year, says alternately that she is thirty or sixty or less than twenty years old, and is very much amazed at being addressed as "Old lady." She is quite unconscious of the grossest contradictions in her statements of time. Thus she asserts that her daughter is two years younger than she, that her father is sixty, when she has just given her own age as sixty, that her child is three years old, and so on. She says that she is living with her parents and grandparents, and calls herself by her

*The patient is still living, two and a quarter years later, and is in a nursing asylum.

maiden name. The Grand Duke's name is Leopold, and the coins she is shown are gulden and kreutzers.

After a little persuasion she quite agrees that she is going to be married soon, and says that a man from the neighbourhood comes to look out for her every day. In other matters, too, she is easily persuaded of anything whatever, and assents when she is told that she had a visitor yesterday, and went for a walk. She spins out such suggestions at greater length herself, and knows who it was that came and what he brought her, and where she went for her walk. But it is very remarkable that, in spite of her accessibility to persuasion, she cannot be led into senseless statements on any other subject than the order of events in time. If you say to her that snow is black, she answers, "Yes, certainly, when soot falls on it." Blood is not black, "but yet dark." Cherries are green "at first, but afterwards they turn red." She understands these contradictions quite well, and often shows a sense of humour. To the question if a thief is not an honest man, she replies, with a laugh, "Yes, but we won't go into that"; and when I tell her she has stolen herself, she answers readily, "I don't usually, but I would have my stupid cough stolen at once."

The rapidity with which the ideas aroused fade again is exceptionally striking in our patient. She forgets everything that happens in a few minutes, and often almost in a moment. She complains to the doctor, immediately after he has given her an injection, that a girl has been there and pricked her. Pure inventions take the place of the real events. Once, when the patient had tied a cloth round her foot, she said in close succession, first that her shoe had come off, and that she had been obliged to tie it on again, then that she had made herself a bandage because a piece of wood had flown against her foot, and lastly, that the doctor had hit her on the foot, and so she had been obliged to tie it up. When experiments were made of showing her pictures and objects, more than a quarter of the impressions were forgotten after only five seconds, while after thirty seconds only a quarter remained, and later none at all. That the patient herself noticed the fleeting character of her ideas is evident from her remark, "I don't know; one cannot hold things any longer in one's whole inside."

The patient's mood is indifferent on the whole, but occasionally peevish, though often merry, with a tendency to joke. She frequently shows a certain degree of unrest, packs up her belongings, and wants to go away to her parents or to the wedding, declares that she has a child in her quilt that must be christened, and is rude when anyone tries to put her to bed again. Her sleep is very much affected by the restlessness, but she takes a sufficient quantity of food, and keeps herself clean with a little help.

The most prominent feature of the case is evidently the almost complete failure of the power to retain impressions, which far exceeds anything we have observed in other forms of disease. The single ideas aroused by subjective and objective occurrences fade again so quickly that absolutely no connected chain of ideas ever comes into existence. Besides this, there are many indications that clear impressions are far more slowly arrived at than is the case with healthy people. Hence many of our patient's ideas vanish before they have ever really become clear. It is easy to understand, to a certain extent, how the united effect of these two disturbances may produce the condition presented by her, which we will call "presbyophrenia."

The great prominence of this inability to retain impressions in the more severe forms of the insanity of old age seems to me to justify the view that those states of depression and excitement in which it is a leading feature, and so increases the probability of an unfavourable prognosis, are also to be considered

as varieties of senile insanity.* If further experience shows that this view is correct, we may perhaps have found a criterion for the distinction of melancholia, as we have previously defined it, from real senile dementia.

CASE 78. Cerebral arteriosclerosis; aphasia and apraxia. Kraepelin (10), p. 215.

If we have expressed the hope that it will be possible to differentiate yet further affections of the cortex from the great provinces of general paralysis, we must at the same time remark that we do, of course, already easily distinguish from paralysis those diseases of the brain which produce no extensive, but rather, I may say, circumscribed, changes in the cortex. You must, then, certainly not mistake for a general paralytic the peasant woman of fifty-eight years whom I will now bring before you. As you will recognise at the first glance, the patient is powerless on the right side. The right arm lies in a semi-flexed position close to the body; the hand which hangs down is of a bluish-red colour, somewhat puffy and cold. In passive movements you notice distinctly a strong spasm in the slightly crooked fingers; one succeeds in straightening them only by using a certain amount of force; the straightening of the arm meets with a slight resistance also. The patient is herself able to accomplish only trivial movements of the fingers and arm. The right leg drags a little in walking. The sensation to touch and to pricking is very much reduced on the right side, but it seems to be somewhat impaired on the left side too; at least, the patient makes no movement of defence. The knee-jerk on the left side is normal; on the right side it is exaggerated, and here slight ankle-clonus also exists. In the movements of the eyes, in the pupils, and in the retina no disturbance is to be found. The pulse is rather full and hard.

A closer examination of the patient is rendered the more difficult as she is completely aphasic. The only words that she is able to pronounce and always repeats are "I will go to bed." It can be seen, however, that she understands simple language. When asked to give her hand or to show her tongue, she is generally able to comply, though very slowly and with difficulty. At the same time, there is an inclination to repeat the same actions, even if afterwards we ask something else of her. She only gradually accustoms herself to new instructions, and apparently does not understand complicated requests at all. She makes a faint effort, if requested, to stretch out the disabled hand, but is quite perplexed if you ask her to take hold of the right ear with the left hand. She then perhaps puts out her tongue, shuts her eyes, or makes similar mistakes.

At first it is of course difficult to say whether this behaviour depends on inability to appropriately carry out properly-willed movements, and consequently on parapraxis, or upon incomplete understanding of the requests. The fact that in alternating requests the patient has at first the decided inclination to repeat the former movement, and then corrects herself, is, perhaps, in favour of the first opinion. But, on the other hand, one does not notice in the patient's certainly very limited, independent actions of the will that she has special difficulties in carrying out her intentions, or that she acts altogether in the wrong way.

But, further, one sees with absolute certainty that, as a fact, the comprehension of words has suffered. If we place two different pieces of money before her, with the request that she is to take the larger or, perhaps, that of the highest value, the sense of the request remains evidently quite obscure to her.

*The patient died three years later in a nursing asylum, after having gradually grown duller.

She takes first one and then the other in her hand, and lays it down again, looking interrogatively at the doctor, without knowing what is required of her. If, however, the object itself offers a certain clue for finding out our meaning, she carries it out without much delay. Thus, with a key she makes the movement of locking, opens a match-box and takes out a match, though with her one hand it gives her a good deal of trouble; she even opens a knife with the help of her teeth. A doctor whom she happened to know formerly she greeted very heartily, nodding to him specially at each visit, and understood that he was spoken of if she was asked to single him out from amongst the others. Now, too, on my asking her, she easily finds out the ward doctor, and nods to him repeatedly in a friendly manner, while she sedulously murmurs away to herself her monophrasic sentence.

From these experiments we venture to conclude that the patient takes in and realizes pretty well in general the impressions offered, but that she understands only imperfectly the words addressed to her. There also exists, along with the complete inability to speak, a marked degree of word-deafness. The patient presents no striking colouring in her emotional attitude; she is in general equable, troubles very little about her surroundings, and sleeps a great deal. When taken notice of, she is friendly; if she is neglected she weeps—as, for instance, when they had forgotten to take her into the garden with the other patients. She expresses neither wishes nor fear. Excitements have not been observed. Her behaviour is quite in order. She keeps herself tidy, eats of her own accord, greets the doctor, and conforms willingly to the prescribed rules.

During the four months that the patient has been with us her condition has not changed substantially, but in the beginning she was not clean, had to be fed, and seemed more demented than now. This circumstance in itself would be sufficient to repudiate the suspicion of a general paralytic affection, since, when that is the case, the occurring symptoms of the central seat of disease, with very rare exceptions, usually disappear again very quickly. We are therefore forced to assume that in this case a more circumscribed damage to the cortex must have taken place in the region of the central lobe, which must have encroached on the third frontal convolution and also on the temporal lobe. As a fact, the patient has been through two apoplectic fits—the first, which was only slight, eight months ago; the second three weeks later, being more severe. After the first attack she could still attend to her housework; after the second almost complete palsy of the right arm and loss of speech came on. At the same time, the patient was sleepless, apprehensive, confused, and excited, wished to put an end to herself, and once even went into the river, but came out again of her own accord. Before this she had always been healthy and cheery. She had had an illegitimate child in her youth. Her grandmother was insane.

We may find it difficult, from want of more definite knowledge, to form an absolute opinion upon the nature of the disease (under discussion) in the cortex of the brain, yet, in consideration of the repeated attacks, the sudden appearance of disturbances without symptoms of an increase of pressure in the cranial cavity, and its long unchanged duration, a vascular obstruction will first occur to us. Affections of the bloodvessels are very frequent at the advanced age of our patient; besides, the great change of the whole mental life, especially in the excessive dullness of the patient, which would scarcely be explained by a circumscribed damage to the cortex alone, points with a certain probability to a more general participation of the cerebral cortex in the process of the disease. We might perhaps venture to think that arterio-sclerotic processes in the bloodvessels of the brain have in the first place brought about general disturbances of nutrition and then local obstructions.

As alcoholic and syphilitic injuries to the bloodvessels are recognised causes of such affections, we took these into account, though for the most part these affections usually make their appearance in the age of involution and in old age, without palpable cause. As, however, the possibility of syphilis was not, at all events, to be excluded, we tried to help the patient by administering iodide of potassium, unfortunately without success. The patient has, perhaps, produced now and then a single word beyond her customary sentence, or may have shown herself a little more active, but on the whole we must make up our minds that a substantial improvement of this apoplectic dementia will not take place; on the contrary, that sooner or later the malady will make further progress through new attacks.*

CASE 79. Cerebral arteriosclerosis; apoplectic attacks. Henry (15), p. 186.

The remarkable preservation of a personality in spite of a series of apoplectic attacks is shown in the case of a druggist who was fifty-four years old at the time of admission. He had been in good health until three years previously when he abruptly developed a weakness of his left side, including the left side of his face. The attack began at night and the weakness increased the following day. He could make only gross movements at first but he gradually regained his strength until at the end of a month he returned to work, apparently recovered.

Four months later he had a second attack consisting merely of a feeling of weakness and nervousness which disappeared in two weeks. Within three weeks he had a similar attack, without paralysis, which incapacitated him for three months.

His fourth attack occurred a year before admission. It began with an "awful pain" in the back of his head, neck and in his temples. Three days afterward he failed to recognize anyone except his wife, had difficulty finding words and didn't seem to know what he was doing or saying. After four weeks spent in a sanitarium he still had difficulty remembering names and in finding words.

The last attack began a month before admission with weakness of the right arm and leg and an increased difficulty in finding words. When he came to the hospital it was noticed that he laughed or cried spontaneously or with little provocation. He was well aware of his illness and there was no obvious impairment of his memory or judgment. There was evidence of well advanced arteriosclerosis and of the residuals from his hemiplegic attacks. His aphasia was so marked that it was impossible to make a routine mental examination.

The following excerpt from an interview is illustrative of his aphasic disorder:

What hurts? "My whatchacallem, you know—what do you call this?" (points to leg) "my stomach—you know—it's so and it's regular turn out—it's just like people do something to you when you've got something wrong with you—I know what I want to say, but I can't say it."

Where does it hurt? "It hurts me whenever this thing gets going" (pointing to his bladder). "It hurts" (laughing) "that thing—I don't know what you call it—to tell you the truth, I'm all mixed—if you take that thing and crack it in half it hurts—if you don't stop it, it hurts like the dickens."

He also was easily confused by any complex situation and he showed a tendency to perseveration. On request he put out his tongue and closed his eyes but then when asked to hold up his right hand he repeated the words "right hand" and closed his eyes. When asked to put his right hand on his left ear he held up

*The patient died a year later in a nursing asylum.

both hands in an uncertain way saying, "right hand, left hand." The request was repeated and the patient again failed to execute the proper movements. He volunteered that he was "a little uncertain." Attempts to identify objects shown to him proceeded as follows: Watch—"Clock." Pencil—"I know what it is but I can't tell." Tongue depressor—"That's similar to the other—you can use it with your hands" (opening and closing hands). Penknife—"The same thing—you use your left hand."

There was little change in the patient's condition until three months later when he developed an acute appendix which ruptured. After a few days with a high temperature, marked retraction of the neck, and a muttering delirium, he died.

In a second case there was no apoplectic attack until shortly before death at the age of fifty-seven. Eight years prior to this the patient, after a long and successful business career, became restless, depressed, said he had committed unpardonable sins and made an attempt at suicide. His blood pressure had been found to be 250 and he had realized that he was failing to meet the responsibilities of his position.

Within six months his illness had developed into an agitated, hypochondriacal depression and he was then admitted to a psychiatric hospital. His responses then were slow and hesitating regarding personal matters. He felt he was the wickedest man on earth and that he was caught like a rat in a trap. His remote memory was adequate but retention was poor except for digits. He was unable to recall any of a test story he had read. He expected that the physician was going to dispose of him in some way.

His heart was considerably enlarged and there was evidence of marked general arteriosclerosis and of chronic, interstitial nephritis. His blood pressure was 190/125 on admission but within a few days it dropped to 165/110. He weighed only 120 pounds although a few years previously he had weighed over 200 pounds.

During the first year in the hospital there was some improvement in his physical and mental condition but he was continuously apprehensive of an "awful upheaval." He was troubled with buzzing in his ears and with noises in his head, resembling the chirping of birds. He said that pictures of familiar scenes, which included his brothers, were thrown on the wall at night. He saw his brothers in distress, heard them calling, and thought they were being murdered. In spite of this he was alert to his surroundings and aware of the nature of his illness. He said, "My head is not right—I worked too hard and worried too much." He continued to express depressive, hypochondriacal ideas. He declared that he was unable to eat and that his bowels did not move. "I'm all dried up—I'm actually through unless you want to keep me for exhibition purposes. I'm the worst case of this kind that ever was. I know I'm a coward. I think I'm a devil. There is something I have done. I am the victim." On two occasions he attempted to drown himself in the bathtub.

Two years after admission he had a fainting spell but within a few days he was able to attend his brother's funeral. He occasionally made trips to his home. His systolic pressure gradually rose until it was 200 or more most of the time but there was no evidence of vascular accident until over seven years after admission. He then developed weakness of the left side of his face and of the right side of his body. Five weeks later he died.

Post-mortem examination disclosed general arteriosclerosis, fibrous myocarditis, chronic nephritis and a recent arteriosclerotic softening of the left external capsule. Histologic examination of the brain showed marked arteriosclerosis of the large and middle-sized vessels with numerous small areas of softening and of gliosis.

CASE 80. Cerebral arteriosclerosis; dementia. Rosanoff (23), p. 505.

J. R. W., male, white, admitted to the Kings Park State Hospital on Feb. 3, 1910, at the age of 62 years.—Patient was raised on a farm where he worked until the age of 27 years, when he became a painter. Efficient in his work, normal in intellectual and temperamental make-up. Married at 25 has had 7 children, 2 of whom died and 5 are living and well. Has always been temperate. Syphilis denied.—At the age of 52 years, i.e., about 10 years prior to his admission to the state hospital, he suddenly became unconscious, was taken to Bellevue Hospital, continued unconscious for about 24 hours, then remained in bed for about a week, and at the end of that time he seemed to recover.—He then remained well for about 5 years, but after that began to ail vaguely and showed gradual reduction of working capacity. During the year preceding his admission he was more or less ill the greater part of the time and in the fall of 1909 became entirely incapacitated, remained at home, developed marked irritability, and was finally committed. —On admission the physical examination showed: elbow, knee and Achilles jerks slightly unequal, left greater than right; facial innervation asymmetrical, lines more deeply marked on right than on left side; grips, by dynamometer, in right hand 80, in left 55 (examiner's grips, 125 and 105 with same instrument); balancing power impaired on either foot; no Babinski sign or ankle clonus; no sensory disturbances except slight bilateral impairment of hearing; faint ticking of watch heard at a distance of not more than 1 inch from either ear, heard by examiner at 12 inches).—Mentally he showed considerable disorientation, memory defect, and general deterioration. Said it was Tuesday, the fourth month, 1904 (actual date Friday, Feb. 3, 1910), gave his age as 52 (actual age 62). "I was fetched here from the place I was working last." Q. Can you name 5 cities in the United States? A. "I don't know as I can; New York, Rhode Island." Q. 9 x 12? A. 120. Q. 15 + 18? A. 28. Q. 9 + 8? A. 19. Q. 14 − 8? A. 6. Q. 100 − 7? A. 97. Thought the hospital was in Brooklyn, although he had just come from Brooklyn, a distance of 45 miles by train. The neighborhood seemed very familiar to him; he thought these were the woods in which he picked cherries years ago.—Subsequent course.—May 25, 1910: At 9 o'clock this morning patient appeared somewhat confused, walked aimlessly about the cottage for about 5 minutes then suddenly became unconscious and fell to the floor; there was no muscular rigidity but, on the contrary, flaccidity; the face was covered with cold perspiration. Patient regained consciousness in half an hour, but was confused and somewhat irritable the rest of the day.—July 9, 1910: In the afternoon the patient was out with the others from the cottage sitting on the lawn terrace near the baseball field. He was not noticed to have any seizure or fainting spell, but when the time came for the patients to return to the cottage it was found that he was paralyzed on the right side; the right leg was so weak that he could not support his weight on it, although when assisted he could make some slight use of it in walking to the cottage, a short distance away. The right side of the face was smoothed out, puffed and pendant.—On being brought to the cottage patient complained of dizziness, did not eat his supper, said he felt nauseated. He appeared dull and confused and the attendant thought he also had difficulty in expressing himself, although it is not clear whether this was due to a true speech disorder or to the mental confusion.—On the following morning the right leg was so far improved that patient was able to walk without assistance, though with some difficulty; the nausea and dizziness had disappeared; the arm remained paralyzed.—On July 11 in the morning, second day after the incident, the arm showed some improvement and at noon it had improved further so that the patient could make some slight use of it in eating. By that time the facial paralysis had disappeared.—In a few days the patient grew much brighter and

the paralysis had disappeared almost entirely, there remaining only some awkwardness in his movements.—Nov. 16, 1910: On waking this morning patient found he was unable to get up. No seizure of any kind had been noticed during the night and he complained of no subjective symptoms. Examination revealed exaggeration of both knee jerks and such weakness of both legs that patient was unable to get out of bed without assistance. When assisted he was able to stand in an awkward position with legs spread apart and even to take a few steps, but was very unsteady and clung to objects to prevent himself from losing his balance. There was no impairment of tactile, pain, or temperature sense, or sense of position; no vertigo or dizziness; no speech impairment. In a few days he recovered almost completely.—Afterward this patient gradually grew more helpless physically and more deteriorated mentally until, around May, 1911, he became confined to his bed. He had to be assisted to and from the bathroom, but eventually grew so apathetic that he would give no sign and would soil and wet his bed. By September, 1911, he was totally disoriented, said he was at home, the month was June.—On Nov. 10, 1911, he suddenly became unconscious and paralyzed on the left side; his breathing was stertorous and he was unable to swallow. On the following day he was cyanotic, temperature had risen to 102° F., pulse 102. Coarse râles were heard over both lungs posteriorly. On November 12 the temperature had risen to 105°, and patient died at 2:20 P.M.

CASE 81. Cerebral arteriosclerosis with dysarthria and aphasia. Henry (21), p. 299.*

A combination of dysarthria and aphasia was presented by a sixty-year-old arteriosclerotic woman who had already had several hemiparetic attacks. She was no longer able to recall names of relatives and referred to her husband as "he." She talked in a monotonous sing-song voice, with the vowels much prolonged. At times her utterances were explosive and high-pitched and there were frequent distortions and omissions of words and syllables. When the physician was presented to her she nodded her head and proceeded: "I thought it was tard en fives—do we have is soon—we'll have this soon—I've been am first to see how getting on—let en do that ...."

Attempts to get her to identify a brooch were not very successful: What is this? "Yes—mine." What do you call it? "No, this is mine—that's very old." What do you call it? "That and this one are the same people—the same year as my cousin." What do you call this? "He had this fixed over—she had it fassed while I'm being here." It was finally discovered that "She's the same one as me" meant she has the same brooch. A few words were always grossly distorted. Girls was pronounced gir-r-rl-l-s, old o—o-ol-l-d, and done lately sounded like do-o-on-n-ne la-a-ately.

This patient not only realized that her speech was defective but she was so embarrassed by it that she refused to speak in the presence of strangers.

CASE 82. Paresis; "galloping paresis." Kraepelin (10), p. 96.

I will now show you a tradesman, aged forty-three, who entered the hospital two months ago. He has complained of headaches for a year, and for four or five months he has fallen off in his work. His eldest brother died of an illness like his own, and he has always drunk a great deal himself. Nothing is known of

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specific infection. The patient became irritable and loquacious a few weeks before his admission, and made great plans. He suddenly bought a bathing establishment for 35,000 marks, although he had no means, ordered 14,000 marks' worth of champagne, and 16,000 marks' worth of white wine, to set up a hotel, bought a dagger and some arsenic, and had an attack in which he became quite rigid.

You can see that the patient is now very much excited. He has torn up part of his clothes, and decorated himself with the shreds in an extraordinary way. He has tied strips round his legs, taken off his jacket, and turned his trousers up high. He chatters unceasingly, and develops the most fabulous ideas of grandeur. He says he will have himself made bigger, so as to weigh 30 stone, is having steel bars put in his arms, wears iron orders weighing 2 cwt., is making himself fifty negresses with an iron machine, will always remain forty-two years old, and is marrying a countess of sixteen, with a fortune of 600 million marks, who has been awarded the rose of virtue by the Pope. He has horses which do not eat any oats, and 100 golden castles, with swans and whales of the stuff the bullet-proof breastplates are made of. He has made great discoveries, has built the Emperor a castle for 100 million marks, is on the most intimate terms with him, has been given 124 decorations by the Grand Duke, and is making every poor devil a present of half a million marks. Besides all this, there are ideas of persecution. They have wanted to murder him five times, and suck two tubs full of blood from his posteriors every night. For this he will behead the warders, or have them torn to pieces by dogs. He is building himself a steam guillotine.

In spite of his continual screaming, chattering, and singing, it is possible to get a few short answers from the patient. He gives his name, knows he is in the "sick-house for madmen," knows the doctors, and can tell the date approximately, but always keeps straying from the subject to return to his fantastic ideas. His mood is exalted and blissful, yet he suddenly begins to weep bitterly when he speaks of the imaginary death of his wife, but immediately goes on to say that he is marrying a baron's daughter with money now. He is irritable at times, and gets into a rage, but is soon quieted by friendly persuasion, and by our entering into his delusions to divert his mind. His speech is hurried and indistinct, with an ill-defined, slurring articulation and syllable-stumbling. His writing shows transposition and doubling of letters, and the characters themselves are unsteady. His features are flabby, and when he speaks there are active sympathetic movements of the face. His tongue trembles strongly, and is put out by jerks. The left pupil is considerably larger than the right, and both are inactive to light. His head is flushed, and his pulse frequent. The skin and knee reflexes are considerably exaggerated. The patient's susceptibility to pain seems to be reduced when his attention is diverted, and, strongly as he is built, his weight is gradually diminishing.

You will see at once that the patient has general paralysis from the result of the physical examination, the extraordinarily disconnected delusions, the feeble mutability of mood, and the ease with which the will is overpowered. Here we see that type of the disease which is usually called the agitated form, from the predominance of strong excitement. This variety of the disease generally develops rather quickly, as it has done in the case before us. There may be remissions in its further course, or the excitement may increase continually, so that the patients succumb in a short time to exhaustion, either in a paralytic attack, or as the result of some other accident. This is called "galloping paralysis." This last possibility is not out of the question in the case before us, for the patient is often quite senselessly excited, injures and dirties himself, and

puts the greatest difficulties in the way of treatment. Our task will consist essentially in taking care that he is properly fed, and in the employment of prolonged baths. The administration of hypnotics—sulphonal, trional, or hyoscin—cannot quite be dispensed with, on account of the patient's extraordinary restlessness. It remains to be seen if we shall succeed in piloting him through his present danger by the means we are employing.*

CASE 83. Paresis; "megalomania." Kraepelin (10), p. 89.

You have before you to-day a merchant, aged forty-three, who sits down with a polite greeting, and answers questions fluently and easily. He is clear about his surroundings and position, and knows the doctors, but makes rather vague remarks about the length of his residence here, and cannot give the year of his marriage or the present date correctly, "because he has not had a calendar for a long time." He says that he was driven crazy by overstrain and badgering, but is quite sane again now, only still rather nervous. His power of work has been very much increased while he has been at the hospital by the good care taken of him, so that he can do a great deal of work, and has the most brilliant prospects. He thinks of starting a large paper manufactory on his discharge, which will be very soon. A friend is giving him the capital necessary. Besides this, Krupp, whom his friend knows very well, has placed a property near Metz at his disposal, where he will go in for gardening on a large scale. The neighbourhood is also very well suited for vineyards. He will have fourteen horses for the farming business, and set up a brisk trade in timber as well, which cannot fail to bring him in a tidy little sum. To the objection that all these affairs will not go off so smoothly, and that they will require large means, he answers confidently that he will overcome the difficulties by his great power of work, and that, with his magnificent prospects, he cannot be short of money. He also hints that the Emperor is interested in him, and will allow him to resume the title his grandfather abandoned for want of means; indeed, he might really use it now. The patient makes all these statements in a quiet, practical tone, behaving in a perfectly natural way.

Even without my telling you that, as a result of his illness, this man's affairs are in anything but a good position, and that he has absolutely no prospect of making anything in the way he proposes, you would have guessed that his is a case of morbid hopes or ideas of grandeur. This is confirmed by the matter-of-course way in which he sets aside the difficulties involved in his projects, and his readiness to extend his plans still further at the least incitement. If you suggest that poultry-breeding might be profitable, he says at once that of course he will keep turkeys, guinea-fowl, peacocks, and pigeons, fatten geese, and set up a pheasantry. This characteristic form of megalomania, the confident throwing out of ever-growing and easily-influenced plans, without any consideration of the difficulties in the way, is in high degree diagnostic of general paralysis. The same kind of thing is certainly observed in maniacal states, but there it is associated with symptoms of excitement, such as flight of ideas, loquacity, and a mood delighting in action, while our present patient, with his supposedly brilliant prospects, seems remarkably quiet and indifferent. We will now remember his uncertainty about dates, besides subjecting him to a searching physical examination.

The patient is a tall, lank, strongly-built and fairly well-nourished man.

*The patient lost weight continually, and succumbed to collapse when he had been three months in the hospital.

His expression is rather languid and tired. The left labio-nasal fold is rather less marked than the right. Both pupils are very small, and show no contraction on exposure to light, while the reaction on looking at a near object is maintained. The tongue shows no tremor; the outspread fingers tremble a little; the knee-jerks are exaggerated. In pronouncing difficult words like "Elektricität" (electricity) or "dritte reitende Artillerie-brigade" (Third Brigade of Horse Artillery), the patient begins to stutter, and brings out the syllables in the wrong order. This form of disturbance of speech, called "syllable stumbling," and indistinct pronunciation of the individual letters, are among the commonest signs of general paralysis. In conjunction with the reflex sluggishness of the pupils, the uncertainty about dates, and the characteristic megalomania, they leave no doubt that the patient is really suffering from general paralysis of the insane.

As to the development of the disease, we know that the patient belongs to a healthy family, but has led a very restless life, and suffered from syphilis. His illness began about two years ago. He became absent-minded and forgetful, to such an extent at last that he was dismissed by the firm for whom he had worked. Then, a year ago, he became excited, made extensive purchases and plans, weeping now and then in the deepest despair, so that he had to be taken into the hospital. On admission, he felt full of energy, "mentally and physically as well as ever," and intended to write verses here, where he was particularly comfortable. He could write better than Goethe, Schiller, and Heine. The most fabulous megalomania quickly developed. He proposed to invent an enormous number of new machines, rebuild the hospital, build a cathedral higher than that at Cologne, and put a glass case over the asylum. He was a genius, spoke all the languages in the world, would cast a church of cast-steel, get us the highest orders of merit from the Emperor, find a means of taming the madmen, and present the asylum library with 1,000 volumes, principally philosophical works. He had quite godly thoughts. These ideas of grandeur changed continually, arising in a moment, to be quickly replaced by others. The patient showed great divertibility, an over-happy mood, easily passing into a tearful one, and great motor unrest. He talked, wrote, or calculated without ceasing, and ordered off-hand everything he saw in the advertisement-sheets of the newspapers—provisions, villas, clothes, furniture, etc. Soon he was Count and Lieutenant-General, presented the Emperor with a whole regiment of field artillery, and offered to move the asylum on to a mountain. Sometimes he was irritable, quarrelled with the other patients, and was destructive, but he always grew tranquil again. There was often retention or involuntary passing of urine.

Two months after his admission the patient began to complain of hallucinations of hearing. Friends stood outside and talked about him, or he heard his children being violated. The news of large presents of money was also communicated to him in this way. Warders seized his sexual parts at night, and there were poison and black-lead in the food. He became gradually and continuously quieter, and fell into the state of mental weakness in which you see him now, devoid of judgment, emotionally dull, and feeble of will. His weight, which fell very much at first, has gradually increased by no less than 20 kilogrammes.*

CASE 84. Paresis; "expansive type." Bluemel (9), p. 396.

Con K., a traveling salesman, employed by a paint company, lost his position through inefficiency. He secured employment with a rival firm, but when calling on old customers he made no mention of his new connections. He showed

*When the paralysis had lasted three and a half years, the patient died, quite demented, of miliary tuberculosis.

curious lapses when sending orders, and wrote "two quarts" or "three gallons" but failed to specify what was wanted. When his superiors called his attention to these discrepancies he argued and became enraged. Soon the difficulties and complications became intolerable and he was discharged. He then wrote letters to other firms asking for employment, but although he began with a request for work he usually ended with some irrelevancy, such as ordering cherry trees. At this juncture the patient went through his old check-books and happened to find an entry of two thousand dollars. He immediately concluded that this money had remained in the bank and had increased at compound interest for many years. Promptly he entered upon an orgy of spending. He promised his niece a $5,000 string of pearls. He talked of building an automobile factory and manufacturing a car which he would name Clara after his wife. He spoke of building a large and expensive home with a basement full of maids. When he was seen in consultation he told the doctor that he was going to make him a colonel and that he himself would be a general. Together with his plans for personal and economic aggrandizement he had many trivial and nonsensical schemes typical of the paretic mind. Thus he decided that the entire family should have their tonsils and adenoids removed. His manner was euphoric and bizarre. When asked to put out his tongue he protruded it in a forceful and grotesque gesture. There was considerable slurring of speech; there was occasional quivering of the lips. The pupils were irregular and sluggish. The knee jerks were normal but were followed by movements in which the patient pantomimed his reflexes.

CASE 85. Paresis; depression followed by paranoid reaction. White (16), p. 193.

Male, age 41; first evidence of any trouble began two years ago, when patient suffered from severe pains in both legs; they were very acute and severe in nature. In March, 1911, he had a vomiting spell, following what is believed to have been a slight convulsion. After this he became peculiar. Following this, for certain irregularities, he was discharged by his employers and subsequently sent to the Washington Asylum Hospital where he remained for two weeks, when he was taken home by his family on a six months' trial. During this time he improved. On his return to Washington, being unable to obtain employment, he became very much depressed, thought that people were against him, believing that he was perfectly well and able to work. His mental condition became such that his family had him admitted to the Laurel Sanitarium, where he remained for five weeks. Shortly before admission to this Hospital there was some sort of an acute outbreak, during which he had several convulsions and he became unmanageable, refused to remain in bed and on this account was brought to this Hospital.

Physcial condition good. Pupils regular, equal, no reaction to light either directly or consensually but they do react to accommodation. Slight nystagmus in each eye on external rotation. No ocular pareses. Tremors of tongue and extended fingers. Knee reflexes exaggerated, right patellar decreased, left absent. No ankle clonus.

On admission he was quite disturbed, especially at night. He threatened to fight the attendants when any attempt to care for him was made. He was very unsteady on his feet, unable to care for himself. It was impossible to get any history from him during early days of his residence here. Irritability was very marked and he would often curse and refuse to answer questions. No insight; no definite hallucinations or delusions. Two months later (January 15, '12) it was noted that he was becoming more quiet, never complained, and his only request was to be discharged.

Since that time patient has greatly improved; he is now quiet and orderly,

oriented in all fields, memory shows no gross impairment, but he has no insight into his condition. Wassermann with blood serum double positive. With the spinal fluid double positive. Protein content increased, 42 cells per c.mm.

CASE 86. Paresis; epileptiform seizures. White (16), p. 197.

Admitted March 7, 1911, age 36 years; married; soldier. Family history negative. Early life uneventful. Army career of good character. Denies alcoholic indulgence and syphilis. For a year preceding admission experienced some difficulty in attending to clerical work; could not concentrate his mind. Memory began to fail, and he was sent into the army hospital, where he remained for a short time, when he secured a leave of several months. When he again reported he was transferred to this hospital. With the first symptoms were slight apoplectiform attack, involving the left side of the body in December, 1909, passing off in 24 hours; disease has been progressive since then.

On admission here, patient was quiet, speech apparently slurred, enunciation poor even in ordinary conversation. Test phrases were at times very indistinctly pronounced. Bradylalia. No insight. Orientation good. No delusions or hallucinations. Right pupil larger than left; both irregular in outline, absolutely no light reaction; they react to accommodation. Knee jerks much exaggerated. General physical condition good.

In May, 1911, a general epileptiform seizure, following which it was noted that patient was confused, dazed and stupid, attacked other patients, and when asked to explain his conduct said that he had been detailed to care for them and they would not obey his orders. He became very much confused, would undress himself in the day room, apparently had no conception of his condition or situation in general. During June, July and August this condition of disturbance continued. In September he was again improved; was up and about the ward. He is disoriented in all fields, has absolutely no insight, memory markedly impaired, and an easily detected speech defect. In November patient appeared somewhat confused, auditory hallucinations became very marked, and he had been carrying on a conversation with the President, but could hear these voices only in the left ear, in which ear, he says he has been somewhat deaf for a long time. He says his reason for not writing his wife is that he can converse with her in Kansas. Persecutory ideas were present. He thought that one of the other patients was going to kill him. He believes that his restraint in bed for the past several weeks is only part of the plan of this patient to kill him. Since then there has been no change.

Wassermann reaction with the blood serum double positive, with the spinal fluid double positive. Fluid clear; protein content increased; Noguchi positive. Cells per c.mm. 62.

CASE 87. Juvenile tabes. Southard and Jarrett (3), p. 216.

The physician's point in presenting Archibald Sherry, the twelve-year-old victim of congenital locomotor ataxia (juvenile tabes) would be to show special pride in his therapeutic results in a rare disease. The case has been presented briefly from the medical point of view as case 38 in Southard and Solomon's case history collection Neurosyphilis. We may here omit the medical details. The layman would, of course, readily observe the unsteadiness of the boy's gait, and would come upon certain oddities in his teeth (typical Hutchinsonian teeth). The psychiatric social worker, like other lay observers, should bring notes concerning superficial oddities of teeth for the physician's consideration and

now and again the worker will be able to throw considerable light upon obscure cases under direct medical observation by retrieving sundry dental facts concerning relatives of the patient, superficially examined in the course of taking histories in the patient's home.

The Sherry boy, after the diagnosis of his syphilis had been thoroughly proved in hospital, was treated and certain pains of his, certain attacks of confusion, and trouble with his speech disappeared upon salvarsan injections, and his gait became steadier.

From the standpoint of social psychiatry, Sherry's family history was of interest. On the father's side there was nervousness (as well as alcoholism and degeneracy). The number of things which "nervousness" may at bottom be is legion; of course no conclusion as to syphilis in the family could be drawn either from a history of nervousness or of degeneracy. The fact that the maternal grandmother had cancer is, no doubt, of no importance. A sister, four years older than Archibald, was also thought to be "nervous" and unstable. One task of social psychiatry was to have this girl examined for syphilis and especially to have her blood and spinal fluid examined. Both blood and spinal fluid failed to yield signs of syphilis.

Instructive also is the fact that Archibald, although always a weak and sickly child, did well in school to the end of his eleventh year, when his capacity to keep up with the other children dropped and he became no longer so amiable and sociable. An odd thing in the case was that the eye-lashes of the boy had turned white during the year.

It was, of course, also the duty of the social service to secure blood reactions of father and mother, who denied syphilis. The reactions of both father and mother proved, in fact, negative, and also, as above noted, that of the older sister. The medical observers remained in doubt as to whether the case was one of syphilitic disease handed down from father or mother, or whether the case was one of a rare or unique condition, namely—"acquired" juvenile tabes. (Concerning the true meanings of the terms hereditary, congenital, and acquired, the psychiatric social worker should make absolutely sure.)

Social work in this case proved difficult by reason of lack of co-operation on the part of Archibald's mother. Treatment could not, in fact, be consistently continued. However, social workers from time to time visited the boy in his home, and he has apparently shown no setback since his initial improvement following a few injections of salvarsan into the blood that were made some six years ago.

Hours spent by
- Physician, 5½
- Psychologist, 0
- Social worker, 42½

Medical record, 9 pages
Social record, 18 pages
Social work:
- Visits, 24
- Interviews at hospital, 3
- Telephone calls, 18
- Letters, 14

CASE 88. Juvenile paresis. Kanner (22), p. 167.*

Howard B. came of an unstable family. His father died in 1929 at the age of forty-three years of alcoholism. He was a lithographer by trade but never held a position for any length of time. He had been a drunkard since adolescence and

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often stayed away from home for several days at a time. He sat around the house "thinking" for hours when sober. The mother died in 1919 of influenza, when Howard was three years old; she had two miscarriages before the birth of the patient, who remained an only child. She was an obese (she weighed 204 lbs.), unintelligent woman. The father's brother, Charles, a saloon keeper, divorced after considerable matrimonial difficulties, died in 1928 of alcoholism and pulmonary tuberculosis. Another paternal uncle, Milton, divided his time between jails, a State Hospital for the Insane ("paranoid condition with alcoholism"), and a State Tuberculosis Sanatorium; when on parole or after escaping from any of these places, he threatened to kill his wife, his sister, and other people and sometimes actually assaulted them. He and his family had been supported by charitable agencies since 1898. The father's third brother, Joseph, "drank himself to death" fifteen years ago; he was syphilitic. Another brother, George, was sober and more stable than the rest; one of his daughters, mentally deficient, had been treated for gonorrhea and had an illegitimate child; one son, twelve years old, I.Q. of 58, had a record of habitual truancy, nailbiting, and frequent masturbation; another son was brought to the Juvenile Court at fourteen years because of larceny.

Howard was born on March 31, 1915. He had pneumonia at six weeks. At three months, he began having convulsions, starting in the left leg "until he shook all over"; they recurred "off and on" for one year. When three months old, he was taken to a dispensary, where the diagnosis of congenital lues was made on the basis of a positive blood Wassermann. His parents did not bring him back for treatment, nor did they submit to the recommended examination of their own blood. He began to walk "weakly" at eighteen months; he did not talk until a little over two years of age. After that he developed well and was considered a "strong, active boy."

Since three years of age, after his mother's death, he was raised by his maternal grandparents. He entered school at six years but missed nearly all of the first two semesters because of measles and bronchitis. He then did very well in his studies for two years. He had always presented a feeding problem and "had to be humored to eat." He was enuretic until about ten years of age. He was spoiled considerably; his grandmother would not let him play with other children, she was afraid "he would be run over or something would happen to him."

He reached the fourth grade at nine years, without any noticeable difficulties. At that time, there developed a marked decline in his scholastic achievements and a deterioration in his general behavior at home and in school. He repeated the fourth grade and, at ten years, he was placed in an ungraded class until his grasp became so defective that the teacher advised that he be taken out of school entirely and kept at home.

During the same period, he became more and more irritable and very restless. He began to cry at the slightest occasion. His speech, which had been clear before, was careless and indistinct. When eating, he got food on his face and hands and clothes.

At the age of twelve years, he had a mental age of seven years and two months (I.Q. 59). At fourteen and a half years, his mental age was five years and two months with a baseline of four and scattering up to seven years (I.Q. 35). During these two and one half years, he deteriorated considerably in every respect. His physical examination showed that his pupils were unequal in size (left much larger than right), irregular in shape, and did not react to light. His speech was inarticulate and indistinct. There were Hutchinsonian incisors and poor development of the dental enamel. The tongue deviated slightly to the right.

Genitalia were underdeveloped and pubic hair was sparse. Ophthalmoscopically, a central macular degeneration was noted in the right eye, and in the left eye there was a large patch of atrophic choroiditis just above and to the temporal side of the nervehead. His vision was impaired as evidenced by groping. He had a prominent Olympian brow. Blood and spinal fluid Wassermann reactions were strongly positive. There was a two plus Pandy and a cell count of 5. The colloidal mastic test was 3321000000.

His behavior, at fourteen and a half years, was that of a child hardly older than three years. He had wet and soiled himself for the past few months. His vocabulary was narrowed down substantially. He mostly occupied himself with a picture book, pointing to objects and talking in a baby-like manner in simple words and phrases, such as "See the dog," or "There is a horse," repeating them over and over. He did not reply to questions but responded to simple requests. There were occasional short-lived crying spells and episodes of screaming and destructiveness.

A few months later, he was reported to put everything he picked up into the stove and to play with fire. He became unable to dress himself. On several occasions he wandered away from home aimlessly. He spoke of hearing and seeing things.

He was committed to a State Hospital in March, 1930. He was inoculated with malaria and later given sulpharsphenamine intravenously and intramuscularly. In September, 1930, he was reinoculated; after that he received bismuth salicylate and arsenicals. He began to have numerous convulsions, sometimes a whole series lasting for a full hour. His gait became unnatural and awkward. His vocabulary was limited to the one word, "pussy cat." He was utterly untidy. A third malaria treatment in March, 1932, and mercury inunction did not halt the progress of his deterioration. Blood and spinal fluid Wassermann remained positive throughout, the cell count rose to 24, the colloidal gold curve in February, 1932, was 5544332100.

At present, the boy is utterly helpless, completely demented, and merely vegetates.

CASES 89a AND b. Post encephalitis; behavior problems. Kanner (22), p. 157.

a. A boy of twelve years, an only child, who had "always screamed louder than other children," had an attack of fever, vomiting, and delirium, which was diagnosed as "influenza," in March, 1926. He was in bed for three weeks. About two weeks after getting up, he again had vomiting spells with pain in the right side of the head and neck, lasting two days. Since then, there was a marked change in his general behavior. He kept barking and growling like a dog and shaking his head, at which time he seemed fully absorbed by his actions. He developed a voracious appetite and gained weight rapidly. He complained constantly of rightsided headaches. He became very restless, quarrelsome, and threw himself about at home and in school. He had temper tantrums. He spoke of being weak in his knees and fell occasionally. He had a small pet dog of whom he had been very fond and whom he had guarded and protected previously; after the change of character had taken place, he cruelly mistreated the animal. There was a coarse tremor of his hands and he held his jaw rather rigidly when talking. At twelve, he had a mental age of a little more than thirteen years.

b. A boy had for two weeks, at the age of five years, a "stupor with some features of delirium," after which he was awake and restless at night and wanted to sleep all the time during the day for a whole year. In the delirium

he had been heard to say "Take that radiator off my chest." For several months following the "stupor," he had unaccountable flights of temperature, up to 105°, with vomiting and drowsiness about twice to three times a week. Since then, according to his parents, he never was the same; he was "like a different child." He became progressively more difficult to manage. After stuttering for about two months soon after the onset, he developed the habit of sniffing. He was afraid of the dark, of dogs, of being hurt, and of traveling in trains "for fear of a railroad wreck" (no one of his acquaintance had ever been in one, nor had he ever witnessed a traffic accident). Since the age of eight years, he grew gradually more and more irritable and had violent temper tantrums, sometimes without any evident provocation. When reading a book, he would suddenly throw it on the floor; afterwards he would cry and feel sorry, saying that "there was something in him, he just could not help it." He would dig scissors into anyone who crossed him; once he chased his grandmother with a carving knife; another time he held his brother, four years his junior, under the water in the bathtub. He had a fierce hatred of his brother (the only other child in the family) since he had wanted a sister and had been promised he would get one. He had talked of getting rid of his brother and of killing him. He hit him over the head when the little boy was three years old; the child "never was without bruises somewhere" inflicted upon him by the senior sibling. When taken to a restaurant and apparently engaged in eating, he suddenly stopped, screamed at the top of his voice, threw the dishes on the floor, cursed his mother, and attempted to run away. He professed to be very religious, prayed a good deal, said that he "does not want to sin." He had become very childish in his play, would not associate with other children, had a battered doll to which he clung all the time; he took it everywhere, dressed it, talked to it, fed it, tried to sew for it, and slept with it. He had a peculiar way of playing with his hands; he pretended that they were dinosaurs, moved them toward one another and made them fight, walked them up imaginary cliffs and acted as if they fell off. His affections varied from demonstrativeness to cold indifference. When observed for some time, he appeared extremely restless, got up, sat down, walked about the room, made constant movements with his fingers and hands, pulled at his sleeves, rubbed the thumb of one hand over the finger tips of the other, twitched his face, etc. When put to bed at night, he would lie and stare at the ceiling and talk to himself for three or four hours, sometimes till three o'clock in the morning; his mother would find him breathing through his teeth and working his hands like claws on either side of the face. In his sleep, he had fright reactions of the pavor nocturnus type. He wet the bed every night. His intelligence remained normal. He was in the course of several years examined by several physicians who declared him to be a "spoiled child." His parents separated on his account; his father said he could not live in the house with such a child, claiming the whole behavior picture was due to the mother's indulgence, as the doctors had said. No school would keep him. Upon the recommendation of Dr. Esther L. Richards, he was placed in a suitable boarding home in the country where, under consistent discipline, he showed steady improvement. He slept ten hours during the night, attended school regularly, and behaved well. A certain amount of overtalkativeness and the respiratory tic of sniffing were kept up for some time.

Date Due

Due	Returned	Due	Returned
JUN 16 1987	APR 28 1987		
APR 16 1990	APR 18 1990 APR 22 1990		
	FEB 08 1993		

22. Kanner, L. Child Psychiatry. 1937. Springfield, Ill.: Chas C. Thomas, p. 527.
23. Rosanoff, A. J. Manual of Psychiatry, 7th ed. 1938. New York: John Wiley & Sons, p. 1091.
24. Sullivan, H. S. Chap. 9, "Affective Experience in Early Schizophrenia," in Schizophrenia. 1928. New York: Paul B. Hoeber, Inc., p. 491.

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KEEP CARD IN POCKET

IT IS IMPORTANT THAT
CARD BE KEPT IN POCKET